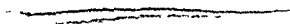


UNITED NATIONS



Fellowship Programme, 1947
Expert Advice on Child Nutrition

WORLD HEALTH ORGANIZATION
INTERIM COMMISSION

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Editorial

The Fellowship Programme 1947

Expert Advice on Child Nutrition

Reports from WHO Fellows Endocrinology in England

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Prevention of Crime

WHO Representation

Forthcoming Meetings

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Venereal Diseases

WORLD HEALTH ORGANIZATION
INTERIM COMMISSION

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UNITED NATIONS
THE OFFICIAL

Fifth Session of the Interim Commission

WORLD HEALTH ORGANIZATION
INTERIM COMMISSION

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UNITED NATIONS

Landmark in World Health
by the Executive Secretary

World Production of Insulin
International Control of Tuberculosis
Co ordination of Medical Abstracting
Towards the Co ordination of Medical Congresses

WORLD HEALTH ORGANIZATION
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BCG and Cholera Vaccine Standardization

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UNITED NATIONS

**International Control of Cholera, Smallpox and Plague
Control of Malaria
Insulin**

**WORLD HEALTH ORGANIZATION
INTERIM COMMISSION**

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First World Health Assembly

WORLD HEALTH ORGANIZATION

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Second Session of the Executive Board
Unification of Pharmacopœias
Pestilential Diseases
Tuberculosis Control

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**European Health Conference
Smallpox Prevalence
Venereal Diseases
Tuberculosis**

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

VOL II, No 1

January 1948

Editorial

At a time when the interim phase of the WHO is drawing to a close, the *Chronicle* is entering upon the second year of its existence. The year 1948 should form a landmark in the annals of international medicine. It will witness the first session of the World Health Assembly, from which will emerge the definitive establishment of the WHO as the highest international authority in the field of public health.

The subjects dealt with in the first volume of the *Chronicle* are evidence that the activities of the WHO—even in its Interim Commission period—have been widespread. But, by the terms of its Constitution, the WHO is concerned with virtually the whole field of medicine and public health. Its scope extends from the international control of communicable diseases to biological standardization, from mental hygiene to the unification of pharmacopœias, from housing to the world supply of insulin. Activities of this widespread and complex nature are the concern not only of Governments and public health administrations but also of practitioners and research workers in many branches of medicine. It is to such members of the medical and scientific professions throughout the world that the *Chronicle* is principally addressed. They constitute the informed public opinion without whose support the work of any international health organization might fail.

The chief purpose of the *Chronicle* therefore, is to keep such people regularly informed of the current activities of the World Health Organization, to provide a continuous record of the views and recommendations of its governing body and of its expert com-

mittees, and, through the medical profession, to bridge the gap between the Organization and those millions of taxpayers who ultimately supply the funds. But even with editions in five languages, the *Chronicle* can never expect to reach more than a small proportion of such a large public. Wider dissemination of information on the activities of the WHO depends upon the Medical Press in the various countries, and in this connexion it is encouraging that a number of medical periodicals have already availed themselves of the general invitation to use material from the *Chronicle* in their columns.

In order to make the *Chronicle* faithfully reflect the WHO and at the same time to bring readers more closely into contact with its work, it is hoped to introduce fresh features from time to time. The first of these—Reports from WHO Fellows—appears in this issue. Suggestions and comments on the *Chronicle*—its contents, presentation, number of pages, etc.—will be welcomed, they are essential to that close contact which is so desirable between the publication and its readers throughout the world.

Fellowship Programme, 1947

The background to the fellowship programme of the Interim Commission of WHO has already been outlined in an earlier number of the *Chronicle* ¹ A report on its operation during 1947 shows that, of the 276 applications received, 203 were favourably considered, while 57 are still under consideration During the year, 23 Fellows completed their courses of study

With the exception of Byelorussia and the Ukraine, all former UNRRA aided countries which applied for medical fellowships have now submitted specific proposals In most of the countries the programme has been completed, with the exception of placing those Fellows whose names were submitted in the latter part of the year or whose placing met with some difficulty Contact was made with the United Nations Social Affairs Department, with UNESCO and with various relief funds and foundations so as to satisfy more thoroughly the needs of the countries for the exchange of personnel as well as to avoid overlapping

In the field, with the exception of minor difficulties such as delay in obtaining visas, unfavourable rates of exchange and transport disturbances, the work has proceeded smoothly The personal contact made with the Fellows whenever they came to the Geneva or New York Offices showed that the fellowships were encouraging a true spirit of international understanding and co operation Their letters and reports have been characterized by an eager search for information, by constructive criticism and by true appreciation for the opportunity provided by the award Some of the reports have been so interesting that it is proposed to publish, from time to time, selections in the *Chronicle* ²

The tables which follow give a numerical picture of the number of Fellows, their country of origin, the country in which they are studying and their particular fields of study

¹ See *WHO Chronicle* 1947 I 114

² See page 9

Table I — NUMBER OF FELLOW BY COUNTRIES OF ORIGIN
as at 31 December 1947

Country of origin	Number of applications	Applications cancelled or withdrawn	Applications still under consideration	Number of awards	Fellows at present studying	Fellowships completed
Austria	13	2	2	9	4	2
China ¹	60	—	16	49	41	2
Czechoslovakia	33	—	3	30	21	5
Finland	10	—	1	9	7	1
Greece	4	—	1	3	2	1
Hungary	5	—	5	—	—	—
Italy	10	—	5	4	2	—
Korea Northern	2	—	—	2	—	—
Korea Southern	2	—	—	2	2	—
Philippines	12	9	—	3	—	—
Poland	70	—	14	51	32	4
Yugoslavia	42	—	9	36	21	8
Totals	371	14	50	203	132	23

A sum of 140 000 U.S.A. dollars was transferred from the Mission operating budget in December which will make available approximately 40 additional fellowships.

Table II — NUMBER OF FELLOW BY COUNTRIES OF STUDY
as at 31 December 1947

Country of study	Number of applications received	Cancelled by WHO	Now studying in country of choice	Fellowships completed
Belgium	3	3	—	3
Canada	5	2	2	—
Czechoslovakia	6	4	3	3
Denmark	13	10	4	4
Eire	1	1	1	—
Finland	1	1	1	—
France	18	11	4	4
Hungary	1	1	—	—
Luxembourg	1	1	—	1
Netherlands	4	4	1	1
Poland	1	1	—	1
Sweden	10	12	8	5
Switzerland	78	26	9	10
U.S.S.R.	12	4	1	—
United Kingdom	38	22	22	11
United States	104 from Europe 17 from Africa	63 67	73 43	3 2
Totals	333	233	162	49

Note: The figures are higher than in Table I as some Fellows are studying in more than one country.

Table III — FELLOWSHIPS IN EUROPE BY FIELDS OF STUDY
as at 31 December 1947

Field of study	Number of Fellow	Field of study	Number of Fellows
Public health administration	20	Anæsthesia	3
Pædiatrics	12	Pathology	3
Cancerology (radiology)	12	Hæmatology	3
Psychiatry (mental hygiene child guidance)	11	Dentistry (dental surgery maxillo facial surgery)	3
Microbiology	10	Endocrinology	3
Internal medicine	9	Nutrition	3
Biochemistry	7	Otolaryngology	3
Thoracic surgery	7	Pharmacology	3
Cardiology	7	Legal medicine	3
Dermatology and venereology	7	Orthopædic surgery	2
Tuberculosis	6	Epidemiology	2
Neurology	5	Hospital administration	2
Surgery	5	Neuro-surgery	2
Urology	4	Public health nursing	2
Immunology	4	Experimental pathology	2
Vital statistics	4	Industrial hygiene	2
Ophthalmology	3	Miscellaneous	11
Allergy	3	Total	188

Note Some Fellows are studying in more than one field

Expert Advice on Child Nutrition

The Report ¹ of a Joint FAO WHO Committee on Child Nutrition will soon be available in printed form in English, French, Spanish, Russian and Chinese ²

The Committee, composed of doctors and nutrition experts with great experience in the problems of child nutrition and knowledge of the urgent needs of children and mothers in many parts of the world, was specifically asked by the United Nations International Children's Emergency Fund (ICEF) to give attention to the following points

- 1 The basic principles of nutrition in planning the purchase and distribution of foodstuffs and in the development of feeding programmes for pregnant women and nursing mothers infants, and pre school children, children of school age and adolescents
- 2 The use of dried whole milk, dried skim milk and cheese in the Fund's operations, and the relative cost of equivalent nutrients in those various forms of milk and milk products
- 3 The value, in the Fund's operations, of the provision of vitamin containing foods, such as cod liver oil and milk, as compared with that of the provision of vitamins in the form of concentrates or multi vitamin and mineral preparations alone
- 4 Recommendations about meals for pre school children (as well as meals for children of school age)
- 5 The relative value of a hot cooked meal in contrast to a cold meal like the Oslo Breakfast

The Committee ³, the first to be convened jointly by the FAO and WHO, met from 23-26 July in Washington, and in its report

¹ Doc. WHO IC, 94 0 August 1947

² In booklet form issued by the ICEF at 1331 Connecticut Avenue N.W. Washington D.C.

³ The Committee comprised the following members

Dr CHEN Professor of Pediatrics National Medical College of Shanghai China
Dr C. CHORRIS Professor of Pediatrics and Director Pediatric Clinic University of Athens Greece
Dr G. FRONTALI Professor of Pediatrics and Director of Pediatric Clinic University of Rome Italy
Dr F. GROER Professor of Pediatrics,

[Continued on following page]

reviewed general conditions of children in war stricken countries of Europe and in China. Evidence was presented that the lack of proper food, especially an insufficient supply of clean milk for pregnant and nursing women and for infants, is one of the most important causes of a high death rate in many parts of the world.

Although the main task of the Committee was to consider the problem of undernourished babies and children, the experts found it necessary to deal at length with the problem of the nutrition of pregnant and nursing women from the point of view of the relation of maternal nutrition to the nutrition of the infant, from that of a selection of foods to meet the nutritive requirements of pregnant and lactating women (need of calories, protein, minerals and vitamins) and from that of the importance of breast feeding.

The nutrition of infants, children between infancy and school age and adolescents was studied in relation to their need of calories, protein, minerals and vitamins. The result of this study is to be found in a number of recommendations which cannot be given here in full, but which may be thus summarized:

(a) The evidence before the Committee showed that pregnant women, nursing mothers, and children of all ages are in need of supplementary feeding in the countries with which the ICEF is likely to be concerned.

(b) Feeding programmes should aim, except in the case of infants, at supplying about a third of the minimum calorie recommendations stated in the Appendix to the Report.

University of Cracow, Poland. Dr E. GORTEN, Chairman, Professor of Pediatrics, Children's Hospital, University of Leiden, Netherlands. Miss M. HESELTINE, Nutritionist, Children's Bureau, Federal Security Agency, Washington, D.C., U.S.A. Dr E. KERPEL-FRONIUS, Professor of Pediatrics, Children's Clinic, University of Pecs, Hungary. Dr F. LEVIA, Associate Staff of Children's Hospital, Washington, D.C., U.S.A. Member of Cuban Medical Federation, Havana, Medical College, late Fellow on Pediatrics, American Academy of Pediatrics. Dr J. F. MALIBEAU, Public Health Counsellor, French Embassy, Washington, D.C., U.S.A. Dr R. McCANCE, Professor of Experimental Medicine, Cambridge University, England. Dr A. P. MEIKLEJOHN, lately Senior Consultant in Nutrition, European Regional Office, UNRRA. Dr A. RÍPKOVÁ, Chief Division Council, Division of Preventive Medicine for Children, Ministry of Health, Prague, Czechoslovakia. Dr W. H. SEBRELL, Medical Director, U.S. Public Health Service, Chief Division of Physiology, National Institute of Health, Bethesda, Maryland, U.S.A. Dr A. SUNDAL, Chief Medical Officer of Schools, Aker, Norway. Dr F. F. TISDALL, Director of Research Laboratories, Department of Pediatrics, University of Toronto and the Hospital for Sick Children, Toronto, Canada. Dr W. R. AYKROYD, Director, Division, FAO, representing FAO. Dr F. G. BOUDREAU, ex-Director, Milbank Memorial Fund, N.Y., Chairman, Food and Nutrition Board, U.S. National Research Council, Washington, D.C., U.S.A., representing WHO/IC.

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(Continued on following page)

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(a) The evidence before the Committee showed that pregnant women, nursing mothers, and children of all ages are in need of supplementary feeding in the countries with which the ICFE is likely to be concerned.

(b) Feeding programmes should aim, except in the case of infants, at supplying about a third of the minimum calorie recommendations stated in the Appendix to the Report.

University of Cracow Poland Dr E. GORTER *Chairman* Professor of Pediatrics Children's Hospital University of Leiden Netherlands Miss M. HESELTINE Nutritionist Children's Bureau Federal Security Agency Washington D.C. U.S.A. Dr E. KERPPEL-FRONIUS Professor of Pediatrics Children's Clinic University of Pecs Hungary Dr F. LEVYA Associate staff of Children's Hospital Washington D.C. U.S.A. Member of Cuban Medical Federation Havana Medical College late Fellow on Pediatrics American Academy of Pediatrics Dr J. F. MALIBEAU Public Health Counsellor, French Embassy Washington D.C. U.S.A. Dr R. McCANCE Professor of Experimental Medicine Cambridge University England Dr A. P. MEIKLEJOHN lately Senior Consultant in Nutrition European Regional Office UNRRA Dr A. RÍPKOVA Chief Division Counsellor, Division of Preventive Medicine for Children Ministry of Health Prague Czechoslovakia Dr W. H. SEBRELL, Medical Director U.S. Public Health Service Chief Division of Physiology National Institute of Health Bethesda Maryland U.S.A. Dr A. SUNDAL, Chief Medical Officer of Schools Aker Norway Dr F. F. TISDALL, Director of Research Laboratories Department of Pediatrics University of Toronto and the Hospital for Sick Children Toronto Canada Dr W. R. AYKROYD Director Division FAO Representing FAO Dr F. G. BOUDREAL ex Director Milbank Memorial Fund N.Y. Chairman Food and Nutrition Board U.S. National Research Council

(c) Attempts should be made to provide one litre of milk daily for all pregnant women and nursing mothers. The provision of smaller quantities than 600 cc may seriously affect the weight and health of infants.

(d) Dried whole milk should be provided for babies under 1 year of age, who are in need of milk. Babies above this age who are below 8 kg in weight should also be supplied with dried whole milk. Infants should be given at least 400 500 international units of vitamin D and 3,000 international units of vitamin A daily, and this should be continued up to the age of 2 years. From 3 to 5 gr of cod liver oil will supply approximately these amounts.

(e) The main supplement provided by ICLF to children between infancy and school age—a most important group neglected in many countries—should consist of dried skim milk, some fat is also desirable. The total supplement of milk recommended was 600 cc. Pre school children should be given 5 g of cod liver oil daily. A hot meal (including milk supplement) during the day is highly desirable.

(f) For children of school age the main supplement should be milk, of which 400 cc daily should, if possible, be supplied by ICLF as reconstituted skim milk. Another 200 cc should be provided from local sources wherever this is possible. Additional calories may be supplied in the form of margarine, fortified by vitamins A and D and by other fats and oil, including lard. Meat or fish would be a most desirable supplement for this age group.

REPORTS FROM WHO FELLOWS

Many of the letters and reports received from WHO Fellows have been of such interest that they deserve to be read by a wider public. They demonstrate more vividly than a series of facts and figures both the character of the fellowship programme and the response of the Fellows themselves. Selections from these reports will therefore be published from time to time, but it must be emphasized that the opinions expressed are those of the Fellows.

* * *

ENDOCRINOLOGY IN ENGLAND

SOME IMPRESSIONS OF A YUGOSLAV FELLOW

Dr Vuk Vrhovac is the Director of the Institute of Clinical Endocrinology of the University of Zagreb Yugoslavia. He organized the first diabetic clinic and the first centre for the manufacture of insulin in Yugoslavia. He has recently spent four months on a study tour as a WHO IC Fellow visiting important centres of research in Sweden, the Netherlands, Denmark, England and Switzerland.

Coming from a country which had been during the war practically cut off from the rest of the world, the first thing I had to do was to study the literature which had appeared during this period. I was surprised to find how many important contributions in the field of endocrinology had been made during the war in England, which had suffered so much and where conditions for research have been certainly far from satisfactory. The new periodical *Journal of Endocrinology* has made it possible for English endocrinologists to publish their papers without waiting for space in American journals. An Endocrinological Society concerned principally with experimental endocrinology has been founded. For clinical endocrinology there is a Section of Endocrinology of the Royal Society of Medicine. I attended very interesting monthly meetings of both these societies and found a profound interest in the medical profession in London in this new branch of medicine.

Endocrinology in England is represented by a considerable number of research workers interested in the different fields of both theoretical and clinical endocrinology, but there does not seem to be an organization or special institution where endocrinology as an entity is studied. This is a disadvantage which makes effective collaboration difficult. Nor does the

personal contact between individual research workers interested in endocrinology seem very satisfactory. The experimental work is published in the *Journal* but there are only a few examples of organized collaboration between experimental and clinical workers perhaps the best being that of Professors H. I. Himsworth and F. G. Young in University College Hospital or on the purely clinical side that of Dr. P. M. F. Bishop and Dr. G. I. M. Sawyer who are working in different hospitals on exactly the same principles. The lack of a special clinical ward in any hospital or medical school where it would be possible to present endocrinology as an entity is a very marked disadvantage. The only place where a co-ordination of different experiences in clinical endocrinology is possible is the Section of Endocrinology of the Royal Society of Medicine where the most interesting cases from different hospitals are shown and discussed.

During my eight weeks stay in London I had splendid opportunities of visiting all the prominent research workers in this field and of discussing with them the main theoretical and clinical problems. At the National Institute for Medical Research I was very much impressed by the interesting work of C. R. Harrington done during the war on the iodination of proteins a rare example of the practical value of research in endocrinology to a nation's economy. The most prominent research worker in endocrinology is Dr. A. S. Parkes who has made valuable contributions particularly in the elucidation of adreno-genital interrelations.

At the Courtauld Institute of Biochemistry of the Middlesex Hospital I met not only Professor F. C. Dadds but also a number of his collaborators a team working on synthetic oestrogens whose work and its clinical application have opened up fresh fields in endocrinology. In University College Hospital where I was very kindly received and introduced by Professor Himsworth I visited the Professor of Biochemistry F. G. Young who is working on the separation of different anterior pituitary principles and is particularly interested in diabetogenic actions of crude pituitary preparations. His experimental work on the permanent diabetic condition produced by pituitary extracts has definitely established the existence of diabetes of pituitary origin probably in human beings also.

In clinical endocrinology I found that in London endocrinology is still divided into that belonging to gynaecology and that to internal medicine. Dr. Bishop is in charge of an Endocrine Clinic at Guy's Hospital where he has introduced all modern methods of gynaecological endocrinology. If he had a ward it might become the nucleus of a centre for clinical endocrinology in London. Dr. Bishop's most interesting work perhaps is at the Fertility Clinic at the Chelsea Hospital for Women. I should like to emphasize particularly the work of Dr. Sawyer at the Obstetric Department of University College Hospital. He came from the National Institute for Medical Research with a sound laboratory background and has introduced many new methods of laboratory examination which are so important in modern endocrinology. He is working on improved methods of pregnandiol estimations conducting an excellent Fertility and Endocrine Clinic and collaborating with Dr. Bishop. His example is a sign of new spirit introduced by the existence of endocrinology as a separate entity in medicine.

An example of a well conducted Thyroid Clinic is to be seen at University College Hospital. Conducted by a very careful clinician Dr W R Trotter this clinic is a model for the treatment of thyrotoxicosis with new remedies such as methylthiouracil. I saw over 300 patients treated in the last three to four years by this method. The best conducted Diabetic Clinic in London is probably that of Dr R D Lawrence at King's College Hospital. I was able to see there a large number of patients and I was very glad to find that the methods of diabetic treatment in my Diabetic Clinic in Zagreb follow the same lines as those of Dr Lawrence. He was very glad too to confirm the same views in regard to modern diabetic treatment.

As an endocrinologist I was particularly glad to see the growing importance of this subject but it seems to me that in England a closer collaboration between experimental and clinical work is urgently needed. Research has made some remarkable achievements but the teaching is not united and should I think be completed by the introduction of endocrinology as an entity in pre clinical and clinical instruction.

The chief advantages of my visit to London were the opportunities afforded of studying the new endocrinological advances both in the literature and in practice. In particular I was greatly interested in the diagnosis of gynaecological disorders due to endocrine imbalance especially the evaluation and treatment of cases of infertility. The clinical application of small doses of thiouracil in the treatment of thyrotoxicosis and the methods of implanting different hormone pellets and synthetic oestrogens both enriched my experience. It will be possible to introduce many of these new advances into the routine work of my Institute for Clinical Endocrinology in Zagreb and I hope particularly to set up a Fertility Clinic of great importance from a social point of view. The treatment of certain endocrine disorders with implants of pellets will not be so easy as these products are very expensive at the moment and are not available in Yugoslavia.

WHO PUBLICATIONS

BULLETIN OF THE WHO Vol 1 No 1

The first number of the *Bulletin of the World Health Organization* has recently appeared. Its title designedly recalls that of its two predecessors the *Bulletin mensuel de l'Office international d'Hygiène publique* and the *Bulletin of the League of Nations Health Organization* which for many years diffused throughout the world the results of international co-operation in the field of public health. The *Bulletin of the World Health Organization* is intended to reflect all the scientific activities of the new agency. It will bring to the knowledge of Governments, health administrations, practitioners, public health specialists and research workers all over the world the communications submitted by the representatives of the Member States, reports from the Expert Committees and original articles by experts and specialists attached to the organization, but this is only a broad general outline which must and will in no way predetermine the final character of the *Bulletin*.

The contents of Volume I No 1 include the report of the Expert Committee on Biological Standardization¹, an extract from the Report of the Expert Committee on Malaria², a series of notes on the immunity reactions following vaccination against smallpox submitted by the representatives from the United Kingdom and from France, a memorandum on post-vaccinal encephalitis together with observations submitted by the representatives from the United Kingdom and the Netherlands³, a note on the estimation of rodent infestation by Dr M T Morgan, two epidemiological studies on the epidemic of relapsing fever in North Africa and a report on the antimalaria campaign in Greece by Dr M J Vine⁴. The greater part of the number is devoted to a report by Dr J B McDougall on the activities of the UNRRA tuberculosis section in Greece. This report has already been reviewed in the *Chronicle*⁵.

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¹ *WHO Chronicle* 1947 1: 103

² *Ibid.* 101

³ *Ibid.*, 80: 171

Ibid. 182

⁵ *Ibid.* 184

NOTES AND NEWS

PREVENTION OF CRIME

Dr M S Guttmacher Chief Medical Officer Medical Service of the Supreme Bench of Baltimore City Court House has been appointed psychiatric consultant to the Interim Commission of the WHO Dr Guttmacher's main task will consist in participating in a special study of the Prevention of Crime and the Treatment of Offenders which is now being undertaken by the Social Commission of the United Nations Such a study was started by the League of Nations but never completed Among the problems Dr Guttmacher will study are heredity as a factor in the causation of crime prevention of crime by giving attention to early social adaptation of children medical and psychiatric factors in the genesis of early criminal careers medical and psychiatric methods for the treatment of juvenile and adolescent offenders and medical and psychiatric care for the treatment of adults in confinement

WHO REPRESENTATION

During the period between 20 December 1947 and 20 January 1948 the Interim Commission was represented by observers who attended or took part in the meetings of the following organizations

Sub Committee of the Advisory Committee on Resettlement of Special
1948 Geneva 7 January

Commission on the Status of Women Lake Success 8 January

Second Session of the Advisory Committee on Resettlement of Special
1948 Geneva 12 January

Sub Commission of the Freedom of Information and the Press Lake
Success 19 January

FORTHCOMING MEETINGS

The Expert Committee on Tuberculosis will meet in Geneva Palais des Nations on 12 January 1948 The Committee outlined at its first meeting held in Paris in July August a plan for combating tuberculosis on an international scale The recommendations of the experts are now under the consideration of the Interim Commission The task of the Expert Committee at its next session will be to discuss the decisions arrived at by the Interim Commission

The Expert Committee on Biological Standardization will meet some time in March. The precise place and date of the meeting will be announced later.

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The Expert Committee on International Epidemic Control will meet in Geneva, Palais des Nations, some time in March or April. The precise date will be announced later.

*

The Expert Committee on Malaria will meet in Washington D.C. some time in May 1948. The precise place and date of the meeting will be announced later.

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CHRONICLE OF THE WORLD HEALTH ORGANIZATION

VOL II, No 2

February 1948

VENEREAL DISEASES — AN INTERNATIONAL PROBLEM

First Session of the Expert Committee
on Venereal Diseases,
Geneva, 12 to 16 January

The introduction of sulphonamides and penicillin has not solved the problem of venereal diseases. The causative organisms of the major infections have been isolated and effective drugs have been discovered, but, unfortunately, to state the cause and indicate the remedy is not to cure the disease. How many problems still await solution was clearly shown in the discussions held at the first session of the Expert Committee on Venereal Diseases¹ which met in Geneva from 12 to 16 January 1948.

Priorities in Venereal Infections

The experts from various parts of the world did not find it difficult to agree from the beginning on the priority to be assigned to the various venereal infections. The major emphasis was

¹ The following attended this session

Professor W. E. COURTS, Chief, Departamento de Higiene Social, Dirección Central de Sanidad, Santiago, Chile

Professor M. GRZYBOWSKI, Clinic of Dermatology, University of Warsaw, Poland

Dr. J. F. MAHONEY, Chief, Venereal Diseases Research Laboratory of the United States Public Health Service, Staten Island, New York, U.S.A. (elected chairman)

Dr. G. L. M. McILLOTT, Adviser on Venereal Diseases, Ministry of Health, London, Great Britain

placed on the control of syphilis, followed by gonorrhoea, chancroid, lympho, ranuloma inguinale, in that order of relative importance.

Although the incidence of late disastrous manifestations in syphilis is perhaps less to day, syphilis still remains the disease which incapacitates patients over long periods of time and thereby presents a grave potential danger. The experts considered that of all forms of syphilis, the early infectious stages represented the greatest problem from the epidemiological and public health standpoint, and the entire work during the session was based upon a recognition of this fact.

In allocating these priorities, the experts were fully aware that their judgment could not have a final and definitive value, as the problems of genital infections of unclassified or ill defined origin still await solution. Dr McElligott reported that in many venereal disease clinics in Great Britain as much as fifty per cent of the cases belonged to this group. Other reports showed that in many parts of the world, especially in South America similar problems were present. These unclassified venereal infections appear to be growing in importance, and Dr Mahoney observed that attempts to isolate the presumed causative virus in his laboratory had so far been unsuccessful. It seemed desirable to the Committee that in view of the existence of this group of genital infections the possibility should be stressed that specific new varieties of venereal infection might be recognized in the future.

The Problems of Diagnosis and Treatment

The medical profession throughout the world has unfortunately not adopted a common attitude either in the diagnosis of syphilis or in its treatment. An effective control programme must depend to a major degree upon the efficient conduct of serological tests for syphilis. It is no exaggeration to say that the variety of sero diagnostic methods in use in every country have created a confusion which may result in an individual being regarded as syphilitic in one country and free of suspicion in another as being syphilitic on one day and healthy on the next.

All the serological tests in current use have their limitations. No single test or combination of tests covers completely the field of

clinical syphilis, all may be influenced by reacting substances produced by infections and disease conditions other than syphilis. However, the possibility of the more stable and more uniform mixtures of cardiolipin and lecithin replacing the lipoidal antigens which have hitherto been employed in serological tests for syphilis, is becoming apparent. This circumstance may prove to be of great value in the serology of syphilis, as it enables some of the variable factors encountered in the older type of antigens to be eliminated. Several years of additional experience and research may nevertheless be needed before the real value of this advance can be estimated.

In the field of therapy, major advances have been made during the past few years, and it seems improbable that the older methods of treatment with arsenic bismuth preparations alone will be selected in any large scale approach to the control of syphilis. The war time discovery of BAL had made the arsenical treatment relatively safe, as it is an excellent means of combating the complications of treatment, such as encephalopathy and exfoliation dermatitis, so much dreaded in the past. Yet, even though these complications may be avoided, arsenical therapy requires application over a relatively long period of time, which many patients are not prepared to undergo. It is thus very difficult, if not impossible, to break the chain of infection.

The advent of new anti-syphilitic drugs and foreshortened methods of treatment during the last few years has introduced conditions very different from those prevailing at the time of the work of the League of Nations on the standardization of anti-syphilitic therapy. Recent developments have shown that regardless of the use of penicillin and arsenic bismuth alone or in any combination, emphasis should be placed on the epidemiological aspects by the use of short term treatment methods designed to reduce infection as quickly as possible.

Penicillin therapy itself has, however, become a highly disputed subject. Some clinicians have reported 90 per cent cures, while others have maintained that 15 to 28 per cent of cases of early syphilis lead to failure unless combined with arsenical preparations. In this connexion, the Committee heard a highly interesting statement from Dr. Mahoney who stressed the fact that many of these reported failures dated from the early experimental use of penicillin therapy. They were based upon treatment with inadequate quantities

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Availability of Drugs

It is, however, obviously useless to adopt or to indicate any large scale plan for control of syphilis unless sufficient quantities of medicaments are available. What is the world situation in this respect?

Many countries, particularly since the war, are short of drugs for treating venereal diseases. Sulphonamides are the most widely available, but a shortage of arsenicals and bismuth is reported from several areas. Production of penicillin is limited to a few countries, and current requirements for the treatment of venereal and other diseases with penicillin cannot be met owing to limited production and other technical reasons.

Yet time was never more pressing. While a favourable situation is apparent to-day, there is no assurance that this will persist. So long as the therapeutic agents upon which reliance is now being placed continue to be effective, satisfactory progress in the control of the communicable stages of the venereal infections may be expected. But it is not impossible that the present antibiotics may encounter a progressively increasing resistance on the part of the causative organisms of gonorrhœa and syphilis. In that event, the control forces would be in a discouraging position, unless and until a replacement for the agents now employed be developed. Although no evidence of such resistance has been so far observed, it would seem provident to press national and international control programmes as vigorously as possible while adequate means of treatment are available. This is why international action is necessary in addition to national efforts and why the Expert Committee, after a thorough discussion, agreed that such international action should be taken without delay.

In considering the problem on an international scale, the experts were not breaking new ground. The League of Nations Health Organization must be credited with holding three international serological conferences in ten years and organizing five inquiries into the methods of treatment of syphilis prevailing in different countries. Other aspects of international action taken in the past which are not sufficiently well known have been summarized in the note on page 24.

International action would obviously necessitate appropriate machinery and legal sanction. The machinery, the Committee

of penicillin, varying from 12 to 28 million units in doses given every three hours. An adequate treatment, in the opinion of the Committee, should be based upon a minimum of 4 million units given in 90 doses of 60,000 units each every two hours for eight days. Practical experience in a large number of cases had shown that this form of treatment was successful in 90 per cent of cases of early syphilis, and if properly applied to pregnant mothers would prevent congenital syphilis in the newborn in 100 per cent of the cases. As a result of the discussion on anti syphilitic therapy there was unanimous agreement that *minimum* standards for penicillin treatment were urgently needed. It was realized, however, that a precise *optimal* form of treatment, preventing undue waste of penicillin, cannot yet be laid down, as these short term penicillin treatment methods have not been applied long enough to permit a final evaluation of the problem.

The discussions showed that international action both with regard to diagnosis, treatment and other aspects was justified, and that the current discrepancies on these problems are the result of the lack of effective pooling of the available information.

Medical Education in Venereology

The recognition of the urgent need for the adoption of standardized diagnostic serologic procedures in syphilis and for minimum standards of treatment led the Committee to consider another major problem—specialized training in venereology. The general practitioner in most countries receives little adequate training in venereology. The subject is seldom considered as an entity by itself, but is taught as a minor appendage to dermatology, internal medicine or neurology. When the general practitioner turns to the medical press for further enlightenment, he is often bewildered by the mass of conflicting opinion on the various methods of diagnosis and treatment. Such a situation can be improved only by a common effort to train venereal disease specialists, and to enable the physician to acquire the latest techniques. The Committee felt that this was an important problem and that unless the same understanding was reached both on the level of the general practitioner and that of the specialist, large scale efforts to combat venereal infections might be unsuccessful.

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International action would obviously necessitate appropriate machinery and legal sanction. The machinery, the Committee

believed, should consist of an expert advisory committee on venereal infections and a section on venereal diseases forming part of the administrative framework of the Secretariat of WHO

FUTURE DEVELOPMENTS

Although final decisions rest with the World Health Assembly, the experts gave detailed consideration to certain technical problems¹

The Committee believed that a substantial economy in the use of penicillin preparations could be achieved if the purified products were used only in the treatment of syphilis and in those cases where amorphous penicillin was of little value. The purification process results in as much as 50 per cent decrease in the active yield during manufacture. There was in the opinion of the Committee, little justification in using crystalline penicillin in the treatment of gonorrhoea. It is clear that penicillin is often wastefully used and it was suggested that the medical profession should be warned that progressive undue use of penicillin might endanger and delay the general availability of this antibiotic. The Committee was of the opinion that steps should be taken by WHO to encourage production to ensure an equal distribution of penicillin to all countries and particularly to those where it is not now available.

Serological Standardization and Laboratory Facilities

If the maximum usefulness is to be obtained from serology in syphilis, certain technical aspects would require detailed consideration. The Expert Committee made in its final report² a series of recommendations with a view to the standardization of technical methods as far as possible. As a step towards bringing the laboratory phases abreast of clinical work the experts recommended that a conference of key serologists from representative areas be convened on the model of the technical laboratory conferences of the League of

¹ This was in accord with the terms of reference of the Expert Committee.

² "That a survey with regard to scientific, practical and other aspects of the problem be pursued with a view to developing practical plans for international combating of venereal diseases and to prepare a report for consideration by the Interim Commission at its fifth session for eventual recommendation to the First World Health Assembly."

³ Document WHO IC/14" 20 January 1948

Nations and the serological standardization conferences of the United States Public Health Service. In any international effort towards uniformity of serological tests for syphilis the Committee believed that the WHO should have at its disposal a first class central reference laboratory, competent to guide international serological work in syphilis and to teach and keep abreast of new developments and procedures. It was recommended that the potential services of existing laboratories should be explored in this respect.

Treatment

The Committee recommended that one of the tasks of the proposed WHO Committee on venereal infections should be to make easily available future evaluations of treatment methods and to induce nations to adopt a reasonably accurate form of therapy.

Training Facilities, Fellowships, Lectureships

In many countries today there is an inadequate number of trained personnel available in the venereal disease field. An appreciation of the rapid advances in the last decade is essential for the effective development of venereal disease control programmes. The Expert Committee suggested that a number of venereal diseases fellowships should be provided and that training facilities in various countries should be studied and designated by WHO so as to expand further this part of the training programme whenever necessary. They also considered that at a later stage provision should be made for lectureships for outstanding specialists in various branches of venereal diseases to visit countries at their request. Finally, the group of experts believed that there was need for a critical international venereal diseases journal and that the provision of information on venereal diseases would be valuable particularly to those countries which have been ravaged by war.

International Health Regulations for Venereal Diseases

Development of faster means of transportation have resulted in a larger number of persons being moved from one area to another,

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³ Document WHO IC/147 29 January 1948

(6) it is desirable that a social welfare worker be available in every large port

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These recommendations, it will be observed, deal only with the medical and public health aspects of the venereal diseases problem. The Expert Committee was fully aware of the vast social implications of venereal diseases but suggested that, as many of these aspects were under consideration by the United Nations and other international organizations, WHO might find it desirable for the moment to concentrate on the technical aspects of the problem, although leaving the way open for a later broadening of the programme. At its fifth session, the Interim Commission approved the report and recommendations of the Committee for an international programme in combating venereal diseases, emphasizing that venereal diseases deserved a high priority among the essential activities of WHO. It recommended that a section on venereal disease control be established in the WHO secretariat and that an expert advisory committee on venereal infections be established, consisting of ten members, to meet twice a year.

and have thus provided further opportunity for the rapid dissemination of venereal infection. The importance of venereal diseases in one occupational group, seamen, had been recognized before the war by measures of an international character such as the Brussels Agreement of 1924.

The Committee was in agreement with the principle expressed by the Economic and Social Council in June 1946 and by the Interim Commission in September 1947¹ on the advantages of replacing diplomatic conventions in technical fields by international regulations, which would no longer require the slow and complicated machinery necessary for the ratification of conventions.

Several Governments have already suggested the revision and extension of the Brussels Agreement of 1924 respecting facilities to be accorded to merchant seamen for the treatment of venereal diseases. The Expert Committee supported these views. It was agreed that the new international regulations should be expanded to include other migrants such as displaced persons, foreign labourers and emigrants, but it was recognized that seafarers are particularly exposed to risk of infection.

The experts finally decided that the new international regulations, to be proposed to the World Health Assembly for adoption, should embody the following basic principles:

(1) medical examination, treatment and drugs and hospitalization where necessary all free.

(2) the services provided should be of the highest professional quality and treatment applied should wherever possible follow such optimal treatment schedules as might be recommended from time to time by the WHO.

(3) an individual treatment book should be provided free of charge to the patient.

(4) it would be advantageous to have an international list of treatment centres including facilities available in inland towns as well as ports.

(5) the epidemiological necessity for treatment of infectious stages of VD is in the interests of the community concerned. A system of international contact tracing should therefore be established in such a way that each country agrees to communicate confidentially directly to the public health authorities of other countries the names and addresses of VD contacts thus facilitating rapid epidemiological investigations.

¹ WHO Chronicle 1947 1 17

WHO PUBLICATIONS

Epidemiological and Vital Statistics Report Incoming Tide of Poliomyelitis

The mutation of the relatively rare Heine Medin disease into epidemic poliomyelitis of world wide extension writes Knud Stowman WHO Epidemiological Consultant¹ undoubtedly next to the 1918-1919 influenza pandemic the most ominous of unsolved mysteries which the last half century has posed to epidemiologists.

Important discoveries have been made in recent years in connexion with the poliomyelitis virus but in some ways they have served only to deepen the mystery. Thus it is that while the virus has been readily demonstrated in the stools the worst epidemics have occurred in countries where sanitation is at a high level and model districts seem as exposed as the poorer neighbourhoods.

The improvement of water supplies in North America Northern and Western Europe is reflected by the spectacular fall of the typhoid fever incidence over the last fifty years. It is precisely in these countries that the tide of poliomyelitis cases has been rising most steadily. It need hardly be pointed out that sewage disposal also has been greatly improved in these countries. Existing evidence is therefore again not considering poliomyelitis a waterborne disease in the sense in which this term is commonly employed.

The notification of poliomyelitis cases has improved since the time of the first epidemics especially during the nineteen twenties but the rise of recorded morbidity in recent years can certainly not be attributed to that cause. Any casual observer of mature age will have noticed that there are many times more polio crippled persons now than forty years ago. The testimony of old medical journals is also there to prove that the Heine Medin disease was nowhere a highly epidemic disease up to the beginning of the twentieth century.

Then came the Scandinavian outbreak around 1905 followed by the 1911-1912 epidemics which caused nearly 8 000 cases in Sweden. In the United States outbreaks in 1912 were followed by the epidemic of 1916 which has so far been the most severe on record. After these spectacular manifestations the disease settled down to a slow but steady geographical extension. The outbreaks came in waves with an irregular number of quieter years in between. Over some thirty years the endemic level grew gradually higher and wave crests too became higher. Although the 1916 epidemic in the United States has not yet been exceeded in any single year the total number of cases reported there during the last five years is about 80 000 which is far in excess of anything hitherto recorded for such a period.

¹ Epidemiological and Vital Statistics Report 1947 1: 114

NOTE ON PREVIOUS INTERNATIONAL WORK ON VENEREAL DISEASES

Several international efforts relating to venereal diseases are on record. These activities fall largely into three groups:

(1) Stimulation of professional thought and research through meetings of venereologists and allied groups at international conferences at intervals.

(2) Collection and dissemination of information pertaining to clinical administrative and scientific aspects of venereal diseases through the League of Nations—the more important programmes being:

(a) Standardization of drugs used—organic arsenicals and penicillin

(b) Regional inquiries into the occurrence of syphilis (Bulgaria)

(c) Standardization of serodagnostic procedures in syphilis (International Laboratory Conferences, etc.)

(d) International enquiries into the methods and results of anti-syphilitic therapy (Scandinavian countries, Great Britain, Germany, France, U.S.A.)—League of Nations Commission on Syphilis and Cognate Subjects

(3) Efforts at control of the spread of venereal disease between nations

(a) Protection of seamen against venereal infections

(1) International Brussels Agreement pertaining to treatment facilities in port—*Office International d'Hygiène Publique*

(2) Health and welfare programmes for seamen in general—International Union against Venereal Disease, International Labour Organization, League of Red Cross Societies

(b) Regional anti-venereal disease programmes, like the Inter-American Health Programme during World War II (i.e. Ipanama Caribbean area, Mexico)—Pan American Sanitary Bureau, Office of Inter-American Affairs, U.S.R.R.'s programmes and anti-venereal disease programmes of military forces during and after the war

A list of references of the League's publications pertaining to venereal diseases can be found in the *Pulletin of the Health Organisation*, League of Nations, Vol. XI, pp. 183, 186 and 203, 204.

In the past international efforts to combat venereal diseases have included approaches emphasizing venereal diseases as part of broad social issues. Thus inquiries into traffic in women and children, sexual exploitation of women and measures of rehabilitation of prostitutes were conducted by the League of Nations and other organizations.

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These general considerations on the trend of the disease in the past are substantiated by a number of valuable statistical details concerning various countries.

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The November 1947 *Epidemiological and Vital Statistics Report* also gives tables of the reported prevalence during the past years in poliomyelitis, cerebro spinal meningitis and influenza.

NOTES AND NEWS

Ratification of the Constitution of the WHO The Present Position

The Constitution of the World Health Organization signed at New York in July 1946 by sixty four Governments—fifty three of which were Members of the United Nations—will come into force when twenty six Member States of the United Nations have become parties to it. The first World Health Assembly must be convened at the latest six months after that date.

Up to 15 January 1948 twenty one Member States of the United Nations had officially ratified or unconditionally accepted the Constitution. They are: China, the United Kingdom, Canada, Iran, New Zealand, Syria, Liberia, Ethiopia, the Netherlands, Saudi Arabia, the Union of South Africa, Haiti, Norway, Sweden, Iraq, Siam, Yugoslavia, Egypt, Turkey, India and Australia.

Nine States which are not members of the United Nations—namely Switzerland, Transjordan, Italy, Albania, Austria, Finland, Rumania and Portugal—have also officially ratified the Constitution.

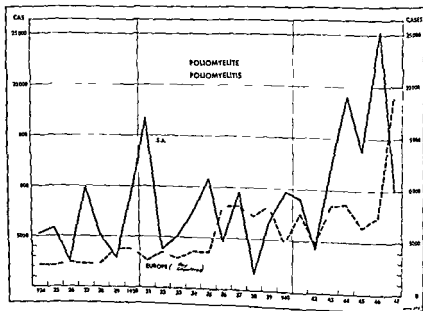
The following Member States of the United Nations have ratified the Constitution without having yet deposited their instruments of ratification: Czechoslovakia, Greece, Poland, Denmark, Mexico, Afghanistan and Brazil. Rumania and Bulgaria, which are not Members of the United Nations, are in a similar position.

Altogether twenty eight Member States of the United Nations and 11 non member States have accepted the Constitution of the WHO, but it should be clear that ratification does not become effective until the instruments have been deposited.

The evolution has been similar in Europe and the United Kingdom has just passed through an epidemic five times greater than any former poliomyelitis outbreak in that country. There are highly significant differences in the incidence of poliomyelitis in the various zones of the world but the disease has actually been recorded in every country endowed with a proper notification system.

The diagram below gives some indication of the general trend of poliomyelitis in Europe and North America from 1924 to date. The European index is composed of data for seven countries — namely the United Kingdom (not including Northern Ireland), France, Italy, Sweden representing Scandinavia, the Netherlands, Switzerland and Austria representing Central Europe. Germany is not included because data for the last three years are incomplete or in places altogether missing. Italian data for 1943 are estimated. The total population of the seven European countries is about 160 millions, that of the United States 141 millions. Notification of cases on the other hand may be more complete in the United States than in France and Italy.

POLIOMYELITIS CASES REPORTED IN THE UNITED STATES AND SEVEN EUROPEAN COUNTRIES 1924-1947



The two curves the author finds show no steady concurrence apart from their general upward trend which has been most pronounced in recent years. In Europe there seems to have been a sudden rise in the epidemicity in 1936 while a similar evolution took place in the United States four years

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The Protocol concerning the "Office International d'Hygiène Publique" comes into force

The States which took part in the International Health Conference in 1946 convinced of the need for a single organization in the field of health decided that although the *Office International d'Hygiène Publique* must continue *de jure* until 1949¹ its functions should be assumed by WHO as soon as the protocol to this effect came into force that is as soon as it had been accepted by twenty Governments parties to the Agreement of 1907

The following twenty two States have now ratified the Protocol Saudi Arabia Bolivia Bulgaria Poland United Kingdom Turkey Union of Soviet Socialist Republics Canada New Zealand Iran Switzerland Italy Denmark Netherlands Australia the United States of America Norway Sweden Iraq Yugoslavia Egypt and India

The following States which are not parties to the Agreement of 1907 have also ratified the Protocol Albania Austria China Colombia Costa Rica Finland the Republic of the Philippines the Byelorussian S S R the Ukrainian S S R Syrian Transjordan Ethiopia Haiti and Eire

WHO Representation

During the period between 20 January and 20 February the Interim Commission was represented by observers who attended or took part in the meetings of the following organizations

Sixth Session of the Economic and Social Council Lake Success 2 February

United Nations Scientific Conference on the Conservation and Utilization of Resources Lake Success 2 February

Regional Meeting of the Near East Food and Agriculture Organization Cairo 2 February

United Nations Maritime Conference Geneva 19 February

Forthcoming Meetings

The Expert Committee on Biological Standardization will meet in Geneva Palais des Nations from 18 to 23 March

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The Expert Committee on International Epidemic Control will meet in Geneva Palais des Nations from 12 to 17 April

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The Expert Committee on Malaria will meet in Washington D C some time in May 1948 The precise place and date of the meeting will be announced later

¹ See *WHO Chronicle* 1947 1 12

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

VOL II, No 3

March 1948

FIFTH SESSION OF THE INTERIM COMMISSION

Geneva, 22 January to 7 February

Members of the Interim Commission concluded their fifth session in Geneva in the knowledge that it would be their last. In his closing remarks, the Chairman, Dr A. Stampar, spoke of the spirit of co-operation that had always prevailed through the debates. The work, he said, had improved from session to session and a genuine friendliness existed among the members in the pursuit of their ideals of world health. He was very hopeful for the future of WHO and emphasized that the series of decisions reached unanimously by the Interim Commission would serve as an example for the international groups which would be called to continue the work.

Although representatives from Liberia, Mexico, Peru and Venezuela were unable to attend this last session of the Interim Commission, the participants in its work were unusually numerous, as many countries sent large representations.

The Commission was confronted with a twofold task. In addition to its current work as the supreme authority in international medicine and public health, it was entrusted with the responsibility of outlining a programme for the Organization proper during the first year of its existence.

Preparation for the First World Health Assembly

The second task of the Interim Commission resulted from the arrangement concluded by the Governments represented at the International Health Conference of New York in 1946 which pro-

vided, among other things, that one of its functions was to prepare and submit to the signatories of this Arrangement, at least six weeks before the first session of the Health Assembly, the provisional agenda for that session and necessary documents and recommendations relating thereto, including

- (i) proposals as to programme and budget for the first year of the Organization
- (ii) studies regarding location of headquarters of the Organization
- (iii) studies regarding the definition of geographical areas with a view to the eventual establishment of regional organizations
- (iv) draft financial and staff regulations for approval by the Health Assembly

The Interim Commission was further obliged by the Arrangement to submit a report of its activities to the Health Assembly at its first session. The Commission set up a Committee on Documentation¹ to consider the form in which these documents might be presented. It was decided that the report should consist of two parts: part I to be the narrative report of its activities and part II constituting the provisional agenda and necessary documents and recommendations. The narrative report which will contain a concise account of the origin and work of the Interim Commission will be a reference document of great value to all who are interested in the history of international co-operation in health matters. The part containing the agenda and recommendations is intended to serve as a working document for the Health Assembly.

Programme for WHO

Consideration of the possibilities for future activities and the preparation for the Health Assembly of a programme for the year 1949, were far more complex and difficult. The fact that the existence of the Interim Commission had been prolonged for two years has resulted in the Commission's assuming considerable responsibilities

¹ Dr H. VAN ZIJL HYDE (United States) Chairman. Dr Nicholas BARAN (Ukraine). Dr Erling VANG (Norway). Dr S. Eining SZR (China). Dr W. A. TIMMERMAN (Netherlands).

and tackling not only those subjects which were statutory obligations inherited from preceding international organizations, the *Office International d'Hygiene Publique*, the Health Organization of the League of Nations and the Health Division of UNRRA, but also other subjects which could not wait until the Organization proper was established

Yet, even if the activities of the Interim Commission were far more extensive than was expected at the time of its establishment, much that has needed to be done has not been accomplished because of financial difficulties. The expenses of the Interim Commission have been kept to a minimum and many of its efforts have consequently been inadequate in the face of the vast health problems of the world.

The Interim Commission has endeavoured to lay solid foundations for the Organization. It realised that WHO, because of its wider terms of reference and greater financial resources, will have greater possibilities for action, and it is suggesting to the Health Assembly budget proposals for the year 1949 totalling nearly \$6,500,000.

Recognizing that WHO will not be in a position in 1949 to develop full programmes in all matters requiring international action, it has recommended that special attention should be given to malaria, tuberculosis, venereal disease and maternal and child health. It has also recommended that particular attention should be paid to alcoholism, habit forming drugs and drug addiction, hygiene of seafarers, influenza, nursing, nutrition, rural hygiene and schistosomiasis. Provision is also made for fulfilling the various tasks and functions inherited from previous international health organizations. These include biological standardization, the development of an international pharmacopœia, international epidemiology, and health statistics. Other projects envisaged allow for fellowships, medical literature and emergency services, and for the many technical publications necessitated by the work of WHO.

Collaboration with Other Specialized Agencies

The spirit of co operation between WHO and other specialized agencies and organs of the United Nations, such as FAO, ILO, UNESCO and UNICEF, was shown by the presence at the fifth session of a number of leading personalities representing the specialized agencies, and by the agreements reached for sharing the responsibility with those agencies in overlapping fields.

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The Food and Agriculture Organization was represented by Lord Horder and Mr F L McDougall, both of whom referred to the effects of low standards of health in many countries on world supplies of food. They both emphasized the need for active co operation and joint action by the two organizations.

The United Nations International Children's Emergency Fund was represented by Dr L Rajchman, Chairman of the Executive Board and former Director of the Health Section of the League of Nations. A programme of mass immunization against tuberculosis, as outlined in detail in a following article¹, was discussed and accepted.

Finally, plans were discussed for the establishment of a close WHO/UNESCO co operation on such projects of medical interest as the co ordination of medical congresses, outlined in this number², or the pilot project of fundamental education in Haiti and the Hylean Amazon project.

Radiotherapy in Cancer of the Uterine Cervix

The *Annual Reports on the Results of Radiotherapy in Cancer of the Uterine Cervix*, which represented an international effort to promote uniform and comparable statistics on the results of the treatment of cancer, are to appear again, sponsored by WHO. The decision by the Interim Commission to co operate in the statistical work required, and to provide the funds for the publication of the results, was taken in response to a request submitted by the British Empire Cancer Campaign (London), the Cancerforeningen (Stockholm) and the Donner Foundation Inc (Philadelphia).

The work is a heritage from the League of Nations Health Organization, the Cancer Commission of which appointed in 1928 a special sub commission of radiotherapists and gynaecologists to study the results of radiotherapy in cancer. Although it was considered that efforts should be made to obtain reliable information regarding cancer of all sites, it was agreed the uterus was the most

¹ See page 34

² See page 38

suitable with which to begin. In 1934, the Health Organization of the League of Nations decided to issue annual reports on the results of radiotherapy in uterine cancer. An advisory committee was appointed to prepare the explanatory observations accompanying the annual statistical statements and to provide guidance on the nature of the commentary. It was entrusted with the publication of the reports, and invited the co-operation of clinics whose statistics fulfilled the requirements of the agreed rules and regulations for the presentation of data and for the calculation of results.

The main object was to secure as much uniformity as possible in the statistical ascertainment of the results of radiotherapy in uterine cancer, so that the value of the different techniques employed might be estimated. Reports were issued in 1936, 1937, 1938 and 1941, the last being delayed because of the war. To promote uniformity in classification, an atlas was published in 1938 illustrating the division of cancer of the uterine cervix into four stages according to the extent of the growth.

In 1940, financial support from the League of Nations ceased, and the expense involved in the printing of the fourth volume was borne by the Cancerforeningen, of Stockholm. Further collaboration on the reports became impossible during the war, but, in the meantime, the rules and regulations laid down by the advisory committee had been almost universally adopted, and the work is often quoted as an example for other branches of medicine.

At the end of the war, Dr J. Heyman, the chairman of the advisory committee, consulted with previous collaborators, all of whom were interested in the resumption of the work. The Cancerforeningen, in Stockholm, the British Empire Cancer Campaign, and the Donner Foundation, in Philadelphia, decided to assume the responsibility previously shouldered by the League of Nations. An editorial committee¹ was appointed in June 1947 with an understanding, however, that this arrangement should be temporary.

In October 1947, the three societies asked WHO, as the only body with the necessary authority and facilities, to assume the responsibility for this work. The formal request stressed the importance, but also the difficulties, of international work of this character. For each different field an expert or a committee of experts would

¹ Dr Malcolm DONALDSON, Mount Vernon Hospital, London. Dr J. HEYMAN, the Radiumhemmet, Stockholm (editor of the Reports). Dr Lewis C. SCHILFEEY, Jefferson Medical College and Hospital, Philadelphia.

be required to propose strict definitions of the disease, suitable classifications of the cases, and uniform rules for calculating the results. Separate committees, it was believed, would also be necessary for following the work and for its further development. It was specifically suggested that it would be necessary to include other sites of cancer in the general scheme, and to have separate committees on malignant disease of the following regions and organs: the skin and lip, the breast, the oral cavity, the otolaryngeal region, the digestive tract, the lung, the central nervous system, the male genital organs and urinary tract, and malignant bone tumours.

Mass inoculation with BCG

The Interim Commission received from the United Nations, International Children's Emergency Fund (UNICEF) a request for support and guidance in carrying out a large scale operation of tuberculin testing and BCG vaccination. The Commission, at its fifth session, noted with satisfaction the development of co-operation with UNICEF and agreed to provide technical advice in regard to its campaign of immunization with BCG. It was clearly understood that the Commission's responsibility was to be limited to making recommendations on the scientific aspects of the campaign, and that responsibility for the actual conduct of the campaign would lie with UNICEF and the contributory Governments. The Commission accepted an offer by the Chairman of the Executive Board of UNICEF to recommend that his board provide funds for carrying out in Geneva, with the assistance of the Secretariat of the Commission, a statistical analysis of the results of the campaign. The Commission is also appointing a special committee on tuberculin and BCG to meet at intervals with representatives of UNICEF, the Danish Red Cross, and contributory Governments. This committee will make periodical assessments of the progress and results of the campaign.

The campaign had its origins in a programme initiated in the spring of 1947 by the Danish Red Cross in co-operation with the Danish Public Health Department and the State Serum Institute,

Copenhagen The programme included the instruction of foreign tuberculosis specialists in methods used in Denmark, and help in establishing and maintaining tuberculosis laboratories but the emphasis was placed on BCG vaccination Before any programme could be undertaken, the first necessities were mass examination and tuberculin testing Both the BCG and the tuberculin were provided by the State Serum Institute To avoid any complications resulting from unskilled use of the vaccine, Danish teams, consisting of three qualified persons—usually a doctor and two nurses—were sent to the countries where the work was being carried out to demonstrate the correct methods The examination and vaccination of the population were arranged in conjunction with the public health authorities and, where possible, with the Red Cross societies of the countries concerned Danish and mixed teams made tuberculin tests and vaccinated the non reactors, fresh vaccine and tuberculin being received from Denmark by air every fourteenth day

The work has already commenced in Poland, Hungary, Czechoslovakia and in the British and American Zones of Germany In the four months following 15 October 1947, about 650,000 persons were examined, of whom about 140,000 were vaccinated, the majority of these being children (115,000) This was anticipated, as it was evident from previous examinations that in the large towns nearly all adults over twenty years were reactors to tuberculin These examinations have involved a total of approximately 1,600,000 consultations

It was soon realized that the work should be extended both by increasing the number of teams working in the different countries and by including in the campaign countries other than those originally selected Such extension would obviously involve considerable expenditure and the possibilities were explored for the establishment of co operation with the United Nations' International Children's Emergency Fund It will be recalled that, as a result of a resolution of the General Assembly of the United Nations, the UNICEF had come into existence in December 1946, as an organization of a special nature created to meet a critical situation The budget of the Fund is expected to be 85,000,000 dollars for 1948, and 10 per cent of this sum was allocated by the Board of Trustees to various medical projects Special attention was given to tuberculosis, and the greatest interest was shown in the offers of collaboration made by the Danish authorities

The Danish Government agreed to place at the disposal of the twelve UNICEF aided countries¹ facilities for training 70 persons in Denmark in the preparation and administration of BCG vaccine. As a result of the negotiations between UNICEF and the Danish Government it was decided to extend the tuberculin testing and the BCG vaccination of children to ten European countries. About 50,000,000 children would thus be tested of whom some 15,000,000 would probably have to be vaccinated. This large programme would require 200 teams 55 of which would be Danish, Norwegian and Swedish, all to be trained in Denmark. The Scandinavian Governments, were willing to share responsibility of this large scale programme and to undertake the organization of the field work. Funds will be provided partly by the Danish Government and partly by the UNICEF and it is hoped that the actual work will begin in 1948.

Improvements in the System of Epidemiological Notification

One of the problems discussed by the Interim Commission was the best way of ensuring rapid and regular dissemination of epidemiological information on dangerous outbreaks of pestilential diseases.

Notifications under the International Sanitary Conventions have been made in the past in respect of the five pestilential diseases. Urgent information has been communicated by telegram to countries which are parties to the Conventions, and to the centres outside Europe concerned with the dissemination of epidemiological data—the Pan American Sanitary Bureau in Washington, the Regional Health Bureau in Alexandria, and the WHO Epidemiological Intelligence Station at Singapore². Such notifications are published later in the *Weekly Epidemiological Record*, together with less urgent

¹ Albania, Austria, Bulgaria, Czechoslovakia, Finland, France, Greece, Hungary, Italy, Poland, Roumania and Yugoslavia.

² From the Geneva Office during the period 1 September–31 December 490 telegrams were despatched 120 of which were in connexion with the cholera epidemic in Egypt between 21 September and 14 December and with the cholera outbreak in Haifa, Syria beginning 20 December.

information. The *Record* is essentially intended for national health administrations and for health services at ports and frontiers, and also provides current data on the application of the Sanitary Conventions, such as quarantine measures imposed and withdrawn. It has a circulation of 900 copies and is published in Geneva. From Geneva it is distributed to European, African and Near Eastern countries, and until 25 July 1947 was reproduced in New York for distribution in the Americas. Other information such as accessions to Sanitary Conventions and authorized aerodromes declared, under Article 7 of the International Sanitary Conventions for Aerial Navigation, 1933 and 1944, to be sanitary aerodromes, is published on mimeographed sheets and circulated to all concerned.

The WHO Epidemiological Intelligence Station at Singapore has in recent months continued its efforts to replace notification telegrams by widening the already considerable network of wireless stations broadcasting its daily and weekly epidemiological bulletins. There are at present eleven stations participating in this work, the most recent addition to the list being Antananarivo (Madagascar) which, thanks to the courtesy of the French authorities, is now broadcasting twice weekly the Singapore bulletin for the benefit of countries on the south east coast of Africa. The *Weekly Fasciculus* issued by the Singapore Station reproduces information received weekly by cable from 282 seaports and airports in eastern countries.

This international service of epidemiological notification has proved of great value to national health administrations. The system can, however, be further improved, and the Interim Commission decided to undertake preparatory studies necessary for the setting up by its Geneva Office of a system of telegraphic broadcasting of epidemiological information extending to the European and African zones the system already in operation at Singapore. At the same time, the possibilities of a system of telephonic broadcasting will be explored, to permit the dissemination of all epidemiological information of a non confidential nature, and the correction, where necessary, of erroneous information.

Pending any decision on such a system, it has been decided that, on the outbreak of an epidemic of a pestilential disease, twice weekly statistical notifications to affected national health administrations will be instituted.

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tional medical science congresses and associations, a representative of the World Medical Association, an observer of WHO, and an observer invited in his private capacity. It was decided that an organizing committee should be formed from the members of the conference to prepare a more representative world conference with the help of UNESCO. This world conference would in turn discuss the proposed project.

At its fifth session, held in January 1948, the Interim Commission of WHO endorsed in principle the proposal made during the Mexico Conference that the co-ordination of medical science congresses should be a joint UNFSCO/WHO responsibility.

Programme for Maternal and Child Health

Among nations, there is a general recognition that children are their greatest asset in terms of human resources, and that to assure for them physical and mental health it is essential that they be born in satisfactory conditions, have the advantage of adequate food, shelter, clothing and maternal care, as well as an opportunity for education and normal family life.

At the fifth session of the Interim Commission, the United States representative submitted a paper outlining a comprehensive programme for maternal and child health and requesting that the subject be placed among those considered of first importance.

The Commission agreed fully with the views expressed by Dr Martha Eliot in introducing the paper, and decided to recommend to the first Health Assembly that the programme proposed be considered top priority along with tuberculosis, malaria and venereal diseases.

The objective of the programme of maternal and child health as recommended by the United States representative is to promote, through international action, the acquisition and dissemination of knowledge, and the establishment and maintenance of services and facilities that will assure to all mothers adequate maternity care, to their infants the best possible chance of survival, and to all children normal growth and development, freedom from all preventable disease, and opportunity to reach adolescence and maturity healthy in body and mind and with an understanding of the factors underlying physical and emotional health security.

WHO and Medical Science Congresses

While WHO has a natural interest in congresses on the medical sciences, the Natural Sciences Division of UNFSCO is also interested in them as part of the pattern of scientific congresses as a whole.

At the second session of the General Conference of UNFSCO held in Mexico City in November 1947, this joint interest was recognized by the proposal that the co-ordination of medical sciences congresses should be shared by UNESCO and WHO.

In 1946, the Natural Sciences Division of UNFSCO had investigated the position of international medical science organizations and had found that most of them had not been active for six years and that many had no permanent organization in the period between congresses. From a questionnaire, it was found that there existed nothing corresponding to the International Council of Scientific Unions which federates all the international organizations in pure science and co-ordinates their activities. An international congress had usually no permanent structure: at each congress officers were elected from the country in which the next congress was to take place and continuity was therefore minimal. There was no co-ordination of the dates of assembly of various congresses or in any other sphere of common interest while not all of the so-called international congresses were truly international in character.

The answers to the questionnaire also indicated that help was both desirable and urgently required and it seemed that assistance could best be provided by setting up a permanent bureau to perform the following main functions:

- (1) co-ordinate the international congresses as to date, place, common fields of interest
- (2) maintain up to date information about all congresses, conferences, meetings held by the International Council of Scientific Unions in bordering sciences and co-ordinate them with the medical science meetings
- (3) deal with all problems connected with arrangements for both the technical and material side of the congresses,
- (4) act as a channel for material help to international unions and congresses in support of their conferences and the travel of officers and guests

A conference was held in UNFSCO House Paris on 7 March 1947, and was attended by the presidents and delegates of 17 interna-

Geneva selected as Seat of the First World Health Assembly

The decision of the Interim Commission at its fourth session to hold the first Health Assembly in the Western Hemisphere was reversed at the fifth session

The discussion regarding the place of the Health Assembly was re opened by the Chairman, Dr A Stampar, who explained that the majority of the European countries had suffered from economic upheavals and would be unable to send large delegations if the Health Assembly were to be held in a hard currency area. It was generally recognized that the most important considerations in the selection of the seat should be the facilities for the efficient organization of the conference by the Secretariat, and the opportunities for the countries which had suffered during the war to send large delegations

After a discussion on the relative merits of London, Paris and Geneva, the last was unanimously selected

Relations with Non-Governmental Organizations

The Interim Commission early recognized that there were great advantages in co operating with non governmental scientific organizations. Although the final choice of the organizations with which collaboration is deemed advisable will rest with the World Health Assembly, a small sub committee was formed to define certain principles of selection, and it was hoped that its report would greatly facilitate the task of the Assembly¹. The principles proposed by the sub committee have now been approved by the Interim Commission, and although they should be regarded only as tentative suggestions and, therefore, not as binding upon the Assembly, they cast some light on the general trend of thought

It was agreed that in its relations with non governmental organizations, WHO should act in conformity with any relevant resolutions of the General Assembly of the United Nations, and that

¹ WHO Chronicle 1947 1 70

The United States representative believed that it was essential to establish within the WHO Secretariat a section on maternal and child health. This section would provide a machinery for the international exchange of information on all subjects with a bearing on the health of the mother and child. It would also be concerned in rendering to Governments such services as field surveys, fellowships, and advice in regard to the training of doctors, dentists, nurses, and members of other professions who may be engaged in programmes for the improvement of maternal and child health.

The WHO programme would have to be developed in close co-operation with other specialized agencies and commissions of the United Nations, such as FAO, UNESCO, UNICEF, and the Social Commission, as well as with various voluntary organizations.

Draft Agreements with the United Nations and with Specialized Agencies

The draft Agreement between the United Nations and WHO¹, which was adopted by the General Assembly of the United Nations at its second session, will be submitted to the Health Assembly for approval.

The text of the draft Agreement between WHO and FAO², which was approved by the Third Annual Conference of the Food and Agriculture Organization, has now been accepted by the Interim Commission and requires only the approval of the Health Assembly to come into force.

Finally, the draft Agreements with the International Labour Organization³, the United Nations Educational Scientific and Cultural Organization³ and the International Civil Aviation Organization³ have also been approved by the Interim Commission and recommended to the Health Assembly for adoption. These draft agreements still require the approval of the general conferences of the three specialized agencies before coming into force.

¹ *Off Rec WHO* no 4 p 118

² *Off Rec WHO* no 6 p 15~

³ To be published.

Geneva selected as Seat of the First World Health Assembly

The decision of the Interim Commission at its fourth session to hold the first Health Assembly in the Western Hemisphere was reversed at the fifth session.

The discussion regarding the place of the Health Assembly was reopened by the Chairman, Dr. A. Stampar, who explained that the majority of the European countries had suffered from economic upheavals and would be unable to send large delegations if the Health Assembly were to be held in a hard currency area. It was generally recognized that the most important considerations in the selection of the seat should be the facilities for the efficient organization of the conference by the Secretariat, and the opportunities for the countries which had suffered during the war to send large delegations.

After a discussion on the relative merits of London, Paris and Geneva, the last was unanimously selected.

Relations with Non-Governmental Organizations

The Interim Commission early recognized that there were great advantages in co-operating with non-governmental scientific organizations. Although the final choice of the organizations with which collaboration is deemed advisable will rest with the World Health Assembly, a small sub-committee was formed to define certain principles of selection, and it was hoped that its report would greatly facilitate the task of the Assembly.¹ The principles proposed by the sub-committee have now been approved by the Interim Commission, and although they should be regarded only as tentative suggestions and, therefore, not as binding upon the Assembly, they cast some light on the general trend of thought.

It was agreed that in its relations with non-governmental organizations, WHO should act in conformity with any relevant resolutions of the General Assembly of the United Nations, and that

¹ WHO Chronicle 1947 1 70

the following criteria should be met before an organization could be regarded as eligible to be brought into relationship

- (1) The organization shall be concerned with matters falling within the competence of WHO
- (2) The aims and purposes of the organization shall be in conformity with the spirit purposes and principles of the WHO Constitution
- (3) The organization shall be of recognized standing and shall represent a substantial proportion of the persons organized for the purpose of participating in the particular field of interest in which it operates. To meet this requirement a group of organizations may form a joint committee or other body authorized to act for the group as a whole
- (4) The organization shall have authority to speak for its members through its authorized representatives. Evidence of this authority shall be presented if requested
- (5) The organization shall normally be international in its structure with members who exercise voting rights in relation to its policies or action
- (6) Save in exceptional cases a national organization which is affiliated to an international non governmental organization covering the same subject on an international basis shall present its views through its governmental organization to which it is affiliated. A national organization may however be included in the list after consultation with the Member State concerned if the activities of the organization are not covered by any international organization or if it offers experience upon which WHO wishes to draw

The Interim Commission also considered that the following privileges should be conferred upon organizations brought into relationship

- (1) The right to appoint a representative to participate under certain prescribed conditions without right of vote in its meetings or in those of the committee and conferences convened under its authority
- (2) Access to non confidential documentation and such other documentation as the Director General may see fit to make available through such special distribution facilities as WHO may establish
- (3) The right to submit memoranda to the Director General who would determine the nature and scope of their circulation. In the event of a memorandum being submitted which the Director General considers might be placed on the agenda of the World Health Assembly such memorandum will be placed before the Executive Board for possible inclusion in the agenda of the Assembly

NOTES AND NEWS

Laboratories Approved for testing Yellow fever Vaccines

The laboratories approved by UNRRA for testing the activity of yellow fever vaccines have now been approved by the Interim Commission. A request for the recognition of the Institute for Medical Research Kuala Lumpur as a vaccine testing laboratory was referred to the Yellow fever Panel.

Immunity after Inoculation against Yellow Fever

The Yellow fever Panel was entrusted with the task of making the studies necessary to determine the time required for obtaining effective immunity after inoculation against yellow fever.

Quarantine Measures during the Cholera Epidemic

The Secretariat was instructed by the Interim Commission to prepare a list of the measures exceeding the provisions in the International Sanitary Conventions taken by a number of countries during the cholera epidemic in Egypt and to ask the Governments concerned for an explanation as to the scientific grounds on which such excessive quarantine restrictions were based.

Biological Standardization

Three pharmacologists will be added to the Expert Committee on Biological Standardization.

*

The question of the standardization of agglutinating serum for cholera was placed on the agenda of the second meeting of the Expert Committee.

*

The strain of cholera isolated in Egypt was obtained by the Chairman of the Expert Committee. This strain is now being kept at the *Centre de collection de types microbiens* at Lausanne and cultures have been despatched to members of the Expert Committee and to institutions in Bucarest, Sao Paulo, Vienna and Zagreb.

*

At the meeting of the FAO Standing Committee on Nutrition (Geneva, September 1947) the question of the standardization of fat soluble vitamins was raised and the desire expressed for close co-operation between WHO and FAO in this field.

Unification of Pharmacopœias

A member representing South American pharmacology will be added to the Expert Committee. Two new members have been recently appointed. They are Dr D van Os (Netherlands) and Dr H Fluck (Switzerland).

*

The Secretariat was empowered by the Interim Commission to enter into negotiations with the Belgian Government for the establishment of a single international secretariat for pharmacopœias under the aegis of WHO.

International Influenza Centre

The Interim Commission agreed at its fourth session to set up an international influenza centre¹. As it was clear that such a centre should be established only in a scientific institution already engaged in research on influenza, an offer was addressed to the National Institute for Medical Research, London, that the centre be placed under this Institute's auspice. A favourable reply was received and Dr C H Andrewes was authorized to assume the direction of the centre. The Executive Secretary will now make the necessary arrangements with the Medical Research Council for the inauguration and administration of this centre.

Medical Statistics

The Interim Commission approved the holding of a third session of the Expert Committee for the Preparation of the Sixth Decennial Revision of the International Lists of Diseases and Causes of Death. The task of the committee will be to incorporate and to edit the changes in the list suggested at its second meeting and to prepare for publication the final versions of the international classification.

*

The Interim Commission endorsed a recommendation of the Committee — which is only a temporary body — for the establishment of an Expert Committee on Health Statistics to carry out all studies necessary to improve the international comparability of public health statistics and to provide expert advice on statistical matters to any technical committee of WHO in need of such assistance.

Radio active Isotopes

Each Government requesting radio active isotopes from the United States is required to designate a representative in the United States to file requests, receive shipments, make payment within the U.S.A. and assume responsibility of the safe handling of the materials in transit, who must be registered with the State Department. The Executive Secretary

¹ See *WHO Chronicle* 1947, 1, 124.

was authorized by the Interim Commission to appoint an official in the Headquarters Office in New York to act as designated representative of those countries which have no scientific attaché in the United States. A reservation was made that the United States Atomic Energy Commission should agree to this arrangement.

Concept of "Health" in the Bill of Human Rights

The United Nations Commission on Human Rights which met in Geneva in December 1947 has incorporated in the Charter of Human Rights the following article:

Everyone without distinction as to economic and social conditions has the right to the preservation of his health through the highest standards of food, clothing, housing and medical care which the resources of the State and community can provide.

The responsibility of the State and community for the health and safety of its people can be fulfilled only by provision of adequate health and social measures.

WHO Representation

During the period between 12 February and 12 March the Interim Commission was represented by observers who attended or took part in the meetings of the following organizations:

Sixth session of the Executive Board of UNESCO, UNFSCO House, Paris, 12 February

Rice Meeting (FAO), Baguio, Republic of the Philippines, 16 February

Preliminary meeting of certain international non-governmental organizations assembled in view of the United Nations Appeal for Children, Palais des Nations, Geneva, 16 February

European Regional Conference of the International Advisory Committee on the United Nations Appeal for Children, Palais des Nations, Geneva, 17-18 February

*

Recent and Forthcoming Meetings

31 March - 2 April Joint Group of Experts on Plague and other pestilential Diseases, *Office International d'Hygiène Publique*, Paris] 154

5 April - 7 April Joint Group of Experts on Cholera, *Office International d'Hygiène Publique*, Paris

8 April - 10 April Joint Group of Experts on Smallpox, *Office International d'Hygiène Publique*, Paris

12 April 17 April Expert Committee on International Epidemic Control Palais des Nations Geneva

19 April 21 April Sub Committee for the Preparation of a Report to First Health Assembly Palais des Nations Geneva

26 April 1 May Conference for the Sixth Decennial Revision of International Lists of Diseases and Causes of Death Paris

4 May 11 May Expert Committee for the Preparation of the Sixth Decennial Revision of International Lists of Diseases and Causes of Death Palais des Nations Geneva

10 May 18 May Consultation of Plague Experts Washington

19 May 25 May Expert Committee on Malaria Washington

31 May 5 June (tentative) Expert Committee on the Unification of Pharmacopœias Palais des Nations Geneva

Annex

LIST OF PARTICIPANTS AT THE FIFTH SESSION OF THE INTERIM COMMISSION

- Dr Andrija STAMPAR President of the Yugoslav Academy of Sciences and Arts Professor of Public Health and Social Medicine at the University of Zagreb Zagreb Yugoslavia *Chairman Representative*
- Dr Paul GREGORIC Member of the Federal Government of the People's Republic of Yugoslavia and President of the Public Health Protection Committee *Alternate*
-
- Dr Ceraldo H. DE PAULA SOUZA Director of the Faculty of Hygiene and Public Health University of Sao Paulo *Vice Chairman Representative*
-
- Dr Aly Tewfik SHOUHA Pa ha Under Secretary of State Ministry of Public Health Cairo Egypt *Vice Chairman Representative*
-
- Dr Szeming SZE Resident Representative Chinese Ministry of Health Washington D C United States of America *Vice Chairman Representative*
-
- Dr Nicholas BARAN Vice Minister Ministry of Public Health of Ukraine Kiev Ukrainian Soviet Socialist Republic *Representative*
- Professor Konstantin VINOCOUPOFF Principal scientific officer Academy of Medical Sciences Kiev *Adviser*
-
- Dr C. VAN DEN BERG Director General of Public Health Ministry of Social Affairs The Hague Netherlands *Representative*
- Dr W. A. TIMMEFMAN Director of the National Institute of Public Health Utrecht *Alternate*
- Dr C. BANNING Chief Medical Officer of Public Health The Hague *Alternate*
- Mr C. J. GOUDSMIT Health Department Ministry of Social Affairs The Hague *Adviser*
- Mrs H. C. HESSLING Ministry of Social Affairs The Hague *Adviser*
-
- Dr Andre CAVAILLON Directeur général de la Santé Ministère de la Santé publique et de la Population Paris France *Representative*
- Dr Xavier LECLAINCHE Inspecteur général au Ministère de la Santé publique et de la Population Paris *Alternate*
- Médecin Général M. A. VAUCEL Directeur du Service de Santé au Ministère France Outre mer Paris *Alternate*

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Dr Nicolai VINOGRADOV Vice Minister of Health Moscow Union of Soviet Socialist Republics *Representative*

Professor Vladimir TIMAKOV Director of the Epidemiological and Microbiological Institute of the Academy of Medical Science of the Union of Soviet Socialist Republics Moscow *Adviser*

Dr Boris VASILIEV Assistant in the Institute of Medicine Moscow *Adviser*

The following were present as Observers

UNITED NATIONS

Mr Louis GROS Executive Assistant Department of Social Affairs

Miss Helen SEYMOUR Senior Liaison Officer Joint Division of Co ordination and Liaison

FAO

Lord HORDER Chairman of Standing Advisory Committee on Nutrition

Mr Frank L McDUGALL Counsellor

Dr John M LATSKY Nutrition Representative in Europe and Chief Nutrition Consultant to the International Children's Emergency Fund of the United Nations

UNICEF

Dr Ludwik RAJCHMAN Chairman of the Executive Board

ILO

Mr E HUTCHISON Member of Section

Mr R E MANNING Secretary

PCIRO

Dr Rodolphe COIGNY Director of Health

OFFICE INTERNATIONAL D HYGIÈNE PUBLIQUE

Dr M T MORGAN President of the Permanent Committee

Dr Maurice GAUD Président de la Commission des Finances et du Transfert

M Eugène J Y AUJALEU Membre de la Commission des Finances et du Transfert

UNESCO

Dr I M ZHUKOVA Counsellor Section of Natural Sciences

The following represented the Secretariat

Dr Brock CHISHOLM Executive Secretary

Dr Raymond GAUTIER Counsellor Chief of the Geneva Office

Dr Frank CALDERONE Director of the Headquarters Office

- Dr Lucien BERNARD Chef du Bureau d'Epidémiologie Ministère
de la Santé publique et de la Population Paris *Adviser*
M René BOLLECKER Administrateur civil au Ministère des Finan
ces Paris *Adviser*
Dr Gérard MONTUS Médecin Inspecteur divisionnaire de la Santé
Marseilles *Adviser*
-

Dr Karl EVANG Surgeon General Department of Public Health Oslo
Norway *Representative*

Dr J BJØRNSSON Chief of Bureau Ministry of Social Affairs
Oslo *Alternate*

Dr H VAN ZILE HYDE Senior Surgeon U S Public Health Service
Washington D C United States of America *Alternate*

Dr Martha M ELIOT President American Public Health Asso
ciation Washington D C *Adviser*

Dr Morton KRAMER Chief Information and Research Office of
International Health Relations U S Public Health Service
Washington D C *Adviser*

Mr John D TOMLINSON Assistant Chief Division of International
Organization Affairs Washington D C *Adviser*

Dr Frederick W JACKSON Deputy Minister of Health and Public Welfare
Province of Manitoba Canada *Alternate*

Dr Ernest COUTURE Director Division of Child and Maternal
Health Department of National Health and Welfare Ottawa
Adviser

Mr John G H HALSTEAD Foreign Service Officer Department
of External Affairs Ottawa *Adviser*

Dr Melville D MACKENZIE Principal Medical Officer Ministry of Health
London United Kingdom *Representative*

Dr A M W RAE Deputy Medical Adviser Colonial Office
London *Alternate*

Mr C H K EDMONDS Deputy Assistant Secretary Ministry of
Health London *Adviser*

Mr L M FEERY Principal General Register Office Somerset
House London *Adviser*

Miss Kathleen V GREEN Ministry of Health London *Adviser*

Lieut Colonel C MANI Deputy Director General Health Services Govern
ment of India New Delhi India *Representative*

Dr George Muir REDSHAW Chief Medical Officer Australia House London
Representative

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

VOL. II, No. 4

April 1948

Landmark in World Health

April 7 1948 will be one of the important dates in the history of international medicine and public health. On that day, the Constitution of the World Health Organization was ratified by the twenty-sixth member State of the United Nations, and thus entered into force.

The need for at least some limited international action against disease was recognized a century ago, but, although this idea steadily gained ground and led to the establishment of several international organizations, the measures taken remained largely defensive and limited in scope.

Modern transportation has now made it impossible for a country to avoid the introduction of disease by the normal quarantine measures. Today no country can depend solely on its own protective arrangements. Each must be assured of satisfactory controls in all other countries as well. The protection of one country against disease depends upon the effectiveness of health administrations in other countries and upon the success of collective action against the epidemic foci which are a constant menace to the well being of most

But the World Health Organization was based upon the idea that more was required than an international system of defence against infectious diseases. It was also necessary that available knowledge and techniques should be pooled internationally and that a positive attempt should be made on a world scale to apply all the resources of the health sciences for the attainment by all peoples of the highest possible level of health. For the first time in history, plans for the establishment of a single health organization covering all aspects of health were laid down, and a Constitution, which has aptly been described as a Magna Carta of health, was signed in New York by representatives of sixty-one governments.

This Constitution is now in force. The list of ratifications was as follows on 7 April ¹

Albania, Australia, Austria, Byelorussian SSR, Canada, China, Czechoslovakia, Egypt, Ethiopia, Finland, Greece, Haiti, India, Iran, Iraq, Ireland, Italy, Liberia, Mexico, Netherlands, New Zealand, Norway, Portugal, Saudi Arabia, Siam, Sweden, Switzerland, Syria, Transjordan, Turkey, Ukrainian SSR, Union of South Africa, United Kingdom, USSR, Yugoslavia

It is confidently expected that at least ten more nations will be able to ratify their signatures in time to become full members of WHO before the first Health Assembly. Particularly, it is hoped that more nations of the Americas may qualify in time for full participation.

At the first World Health Assembly, to meet in Geneva on 24 June 1948, there will be no distinction between those members of WHO which are also members of the United Nations and those which are not. All will have equal right of participation and vote. All the sixty-seven nations which were invited to send delegations to the International Health Conference in New York in June 1946 but which have not yet accepted the Constitution of WHO or ratified their signatures to it, are being invited to send observers to the Health Assembly. Such observers may participate in discussion, on the invitation of the President, but will not have the right to vote. Other participants, as observers, in the Health Assembly will be the representatives of the United Nations and of the other specialized agencies.

Switzerland's long history of peaceful international co-operation, the tradition of the very successful Health Section of the League of Nations, and the services provided by the United Nations in the Palais des Nations, make Geneva an ideal choice as a site for the first World Health Assembly.

About five weeks of very hard work for all the delegations are indicated by the extensive agenda, but the coming into existence of WHO itself has been too long delayed and its Constitution points to enormous responsibilities which need the immediate attention of the nations of the world.

BROCK CHISHOLM, M.D., *Executive Secretary*

¹ Afghanistan, Denmark and Iceland ratified after that date. Bolivia, Brazil, Bulgaria, Hungary and Roumania also completed the process of ratification, without however having deposited as yet the instruments of ratification.

World Production and Consumption of Insulin

Many countries have been experiencing difficulty in obtaining adequate supplies of insulin. Insulin factories have not been able to procure the necessary pancreas, and present currency restrictions have hampered normal commercial relations, while more efficient methods of diagnosis of diabetes, and the greater number of surviving diabetics have increased demand. Attempts to produce a synthetic substitute for insulin have not so far met with success and there seems to be no immediate prospect of increasing supplies in this war.

A shortage of insulin would have the gravest consequences for many diabetics, and the Interim Commission therefore decided to send a questionnaire to governments, asking for information on their consumption and production of insulin and for an estimate of their prospects in regard to insulin supplies for the next ten years. Up to 1 April 1948, replies had been received from forty-four countries.¹ Some of the replies received were incomplete and the figures below can be regarded only as giving a very broad indication of insulin needs and production.

Consumption

The information received indicated that the consumption of insulin, excluding the United States and Canada, for which figures were not available, and Ethiopia and Liberia, where consumption is negligible, amounted to 3,901,000 000 international units. This

¹ Afghanistan	El Salvador	Japan	Syria
Alabama	Ethiopia	Liberia	Transjordan
Austria	Finland	Luxemburg	Turkey
Belgium	France	Mexico	Union of South
Brazil	Germany (American British and French zones)	Netherlands	Africa
Canada		New Zealand	United Kingdom
Chile		Norway	United States of
Czechoslovakia	Greece	Peru	America
Denmark	Hungary	Republic of the	Uruguay
Dominican Republic	India	Philippines	Venezuela
Ecuador	Iraq	Southern Korea	Yugoslavia
Egypt	Ireland	Sweden	
	Italy	Switzerland	

¹ One kilogram of pancreas gland if properly processed will yield on an average 2 000 units of insulin.

This amount may vary a good deal in accordance with the method by which the gland is handled and the condition of the cattle used. Generally an English pound (about 450 grams) of pancreas gland would be obtained from 225 oxen, 3 pigs or 12 calves.

figure would appear to include in most countries—the American, British and French zones of Germany excepted—insulin used in the treatment of diseases other than diabetes

Figures from many countries are lower than might have been expected from the total number of inhabitants, probably because only the urban population in such countries receives insulin. Insulin consumption in other countries may be attributed to well organized health services and a skilled medical profession. Insulin consumption during the next ten years, with the exception of the four countries previously mentioned, is estimated to total approximately 46,425,000,000 units

A comparison between the present consumption and that estimated for the next ten years shows an average increase of one fifth, but it is possible that the actual increase may be much larger. Increased consumption will depend upon improvements in public health organization and on dietary factors

Production

The present production of insulin in forty three countries¹ is 11,087,300,000 units. Most of this is produced by the United States, but the United Kingdom and the Netherlands are also large producers

If the slight improvements foreshadowed in certain countries other than the chief producers materialize, total production for the next ten year period may well reach 115,250,000,000 units. The estimated ten year consumption of 46,425,000,000 units does not however, include the requirements of the United States, which has one million diabetics and which can export only a relatively small quantity of insulin

Steps taken to increase Production

Most countries producing insulin have taken steps to increase production. Many have made the collection of pancreas of slaughtered animals obligatory, while others have granted subsidies to encourage such collection. In a few countries slaughterhouses have

¹ No precise figures were received from Canada which reported that its production was adequate to its needs

been provided with refrigerators and modern apparatus. In the United States, official control of slaughterhouses has brought about a considerable rise in the production of insulin, and the authorities have taken some responsibility for training factory personnel and have drawn attention to the serious need for adequate supplies of insulin.

Important steps have also been taken in the American and British zones of Germany for the effective recovery of pancreas, and it is likely that these will yield satisfactory results. The method of extracting insulin of the "Depot Insulin Klar" type will result, it is claimed, in a 30 per cent increase in production. Finland, Czechoslovakia and Yugoslavia are hoping to increase their supplies by this method.

A discovery which may prove of great value has recently been made in Germany. A new method, reported to have yielded very favourable results, obviates the necessity for refrigerating plant, and should enable the recovery from small slaughterhouses of most of the glands which would otherwise have been wasted for lack of cold storage facilities. If this method proves satisfactory, it will not only reduce installation costs, but will increase considerably the quantities of glands available for the production of insulin.

According to the occupation authorities in the British zone of Germany, research has shown that cod pancreas is very rich in insulin. Unfortunately, the cost of extraction is about 150 times greater than that from animal glands.

Import Needs and Exportable Surplus

Thirty four¹ of the countries which replied to the questionnaire were not self sufficient in regard to insulin supplies, and estimated their import requirements at approximately 1,854,000,000 units per year, while the exportable surplus of the producing countries was about 1,430,000,000 units. These figures show a deficit of 424,000,000

¹ Afghanistan	El Salvador	Italy	Southern
Albania	Finland	Japan	Korea
Austria	France	Luxemburg	Switzerland
Brazil	Germany (Ameri	Mexico	Syria
Chile	can British and	Netherlands	Transjordan
Czechoslovakia	French zones)	New Zealand	Turkey
Dominican	Greece	Norway	Union of South
Republic	India	Peru	Africa
Ecuador	Iraq	Republic of	Uruguay
Egypt	Ireland	Philippines	Venezuela

units, which could probably be covered partly by the surplus production of the United States and partly by the increased yield of insulin expected as a result of improved methods of extraction. But it must not be forgotten that the consumption of insulin in the United States is extremely high. It should also be noted that no report has yet been received from China, with a very large population, and a medical service which is expected to expand considerably in the future.

It is difficult to forecast with any accuracy the exportable surplus of insulin and the import needs for the next ten years. The main producing countries have expressed their willingness to do all in their power to meet requirements. The recent improvements both in the collection of glands and the extraction of insulin would seem to justify a reasonably optimistic view of the future.

International Control of Tuberculosis

The ultimate objective of an international programme of tuberculosis control would be the prevention and eventual eradication of the disease. But in present conditions, many countries are unable by their own efforts even to hold the disease in check. Malnutrition, unsatisfactory housing conditions and general economic distress complicate the task of the doctor and the public health worker, and make it essential for international organization in the distribution of available resources so that they will do the most good in the shortest time.

To advise on its future policy concerning this major health problem, the Interim Commission in March 1947 appointed an Expert Committee on Tuberculosis. The committee's first session was held in Paris from 30 July to 2 August 1947 and the second from 17 to 20 February 1948 in Geneva.

At the first session, some of the principal measures in the tuberculosis control programme of the future Organization were outlined. The first necessity was to determine the extent of tuberculosis in each country and to evaluate the means and facilities for control at its disposal. The problem once defined one of the most important measures to be taken was the recruitment and training of professional personnel. In most countries there is at present an inadequate number of well trained workers. To improve this situation travelling

Fellowship should be awarded to countries principally to train tuberculosis officers in administration and epidemiology, and in laboratory and clinical work. It was estimated that one thousand such fellowships could usefully be granted by WHO within the next few years but the committee agreed that only fifty of these should be provided in the first year.

The provision of supplies and equipment for all phases of prevention, diagnosis and treatment was judged second in importance only to the provision of personnel. WHO should be prepared to give advice to various countries requesting such information on the number, type, location of equipment and on the best means of financing their construction and maintenance, taking advantage of the experience of other countries. But such advice should be given only if it were to form part of a long range comprehensive plan for a country and its administrative subdivisions.

Health education was recognized as essential in tuberculosis.

The general public must know the seriousness of the disease, its cost in human happiness and money before it would accept financial responsibility for the work. Education of the medical profession, too, was essential and it was recommended that WHO should prepare and circulate from time to time material on recent developments of special importance. Advice should also be given to governments, on request, on suitable laws and regulations pertaining to human and bovine tuberculosis.

The best method of starting a new, or of improving an old, programme appeared to be the use of field services to demonstrate practical activities in tuberculosis administration, epidemiology, laboratory or clinical work. Well trained teams, even with limited resources and equipment, can demonstrate more vividly than any other method the practical aspects of control. An essential condition for the provision of such teams must be that the country agrees beforehand to take over the project as soon as sufficient of its personnel has been trained to do so, and to use it as a national training-centre. In research the committee thought that the best contribution to be made by WHO would be in developing and recommending uniform procedures. The principal problems needing action were listed as follows:

- (1) Tuberculin and tuberculin testing
- (2) Preparation and clinical use of BCG
- (3) Classification of tuberculosis

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The provision of supplies and equipment for all phases of prevention, diagnosis and treatment was judged second in importance only to the provision of personnel. WHO should be prepared to give expert advice to various countries requesting such information, on the number, type, location of equipment, and on the best means of financing their construction and maintenance, taking advantage of the experience of other countries. But such advice should be given only if it were to form part of a long range, comprehensive plan for the country and its administrative subdivisions.

Health education was recognized as essential in tuberculosis control. The general public must know the seriousness of the disease and its cost in human happiness and money before it would accept financial responsibility for the work. Education of the medical profession, too, was essential, and it was recommended that WHO should prepare and circulate from time to time material on recent developments of special importance. Advice should also be given to governments, on request, on suitable laws and regulations pertaining to human and bovine tuberculosis.

The best method of starting a new, or of improving an old, programme appeared to be the use of field services to demonstrate practical activities in tuberculosis administration, epidemiology, laboratory or clinical work. Well trained teams, even with limited supplies and equipment, can demonstrate more vividly than any other method the practical aspects of control. An essential condition for the provision of such teams must be that the country agrees beforehand to take over the project, as soon as sufficient of its personnel has been trained to do so, and to use it as a national training centre. In research, the committee thought that the best contribution to be made by WHO would be in developing and recommending uniform procedures. The principal problems needing action were listed as follows:

- (1) Tuberculin and tuberculin testing
- (2) Preparation and clinical use of BCG
- (3) Classification of tuberculosis

units, which could probably be covered partly by the surplus production of the United States and partly by the increased yield of insulin expected as a result of improved methods of extraction. But it must not be forgotten that the consumption of insulin in the United States is extremely high. It should also be noted that no report has yet been received from China, with a very large population, and a medical service which is expected to expand considerably in the future.

It is difficult to forecast with any accuracy the exportable surplus of insulin and the import needs for the next ten years. The main producing countries have expressed their willingness to do all in their power to meet requirements. The recent improvements both in the collection of glands and the extraction of insulin would seem to justify a reasonably optimistic view of the future.

International Control of Tuberculosis

The ultimate objective of an international programme of tuberculosis control would be the prevention and eventual eradication of the disease. But, in present conditions many countries are unable by their own efforts even to hold the disease in check. Malnutrition, unsatisfactory housing conditions and general economic distress complicate the task of the doctor and the public health worker, and make it essential for international organization in the distribution of available resources so that they will do the most good in the shortest time.

To advise on its future policy concerning this major health problem, the Interim Commission in March 1947 appointed an Expert Committee on Tuberculosis. The committee's first session was held in Paris from 30 July to 2 August 1947 and the second from 17 to 20 February 1948 in Geneva.

At the first session, some of the principal measures in the tuberculosis control programme of the future Organization were outlined. The first necessity was to determine the extent of tuberculosis in each country and to evaluate the means and facilities for control at its disposal. The problem once defined, one of the most important measures to be taken was the recruitment and training of professional personnel. In most countries there is at present an inadequate number of well trained workers. To improve this situation, travelling

The organization of a conference on streptomycin is now well under way, and it is hoped that it will be held in July, probably in New York. Although the participants have not yet been chosen, it was agreed that they should be selected from workers with the widest experience in the clinical application of the new antibiotic, rather than in its laboratory aspects, for the discussion will bear mainly on problems of therapeutic application. It was agreed that the total number of the participants should not exceed five.

A long discussion was held on BCG vaccination, which is at present—in the opinion of the committee—the best practical method of inducing specific resistance to tuberculosis in man. Evidence from many countries indicated that BCG vaccination can reduce morbidity and mortality in tuberculosis. BCG vaccination is not intended to replace other aspects of tuberculosis control, such as case finding, medical care and segregation, but it has an important role to play, especially in countries or groups of people where the prevalence of tuberculosis is high. The vaccination is known to convert a high proportion of non reactors into reactors to tuberculin. The intracutaneous method appears to give the highest percentage of conversions, and was therefore recommended as the most satisfactory one for general use.

The committee recommended, on the basis of extensive recent experience, that in those countries in which PPD (purified protein derivative) is used for tuberculin testing, the following doses should be used prior to vaccination (the doses refer to the special batch of PPD used in Copenhagen as the Danish standard)

First dose	—	0.00002 mg PPD
Second dose	—	0.0002 mg PPD

The test should be read within 72 hours to 96 hours after application. Persons designated as reactors must show 6–8 mm of œdema or infiltration. Erythema of the skin should be disregarded in reading reactions. Vaccination should be given only to those persons who are non reactors to 0.0002 mg of PPD.

Finally, the committee discussed the proposed programme of co-operation between the United Nations International Children's Emergency Fund (UNICEF) and WHO in the vaccination with BCG of approximately 15 million children and adolescents in Europe. The committee recommended that this project be developed as quickly as possible and welcomed the opportunity to act as advisers.

- (4) X ray interpretation and mass radiography
- (5) Laboratory identification of tubercle bacilli
- (6) Evaluation of new therapeutic agents such as streptomycin

It was recognized that other international organizations had been carrying on activities and had made many contributions to tuberculosis control. The committee was informed that the Union internationale contre la Tuberculose was about to establish a branch office in Geneva, and it was urged that liaison be established between WHO and the Union to co-ordinate their several activities. Co-operation with all private and official agencies, even those only partially engaged in tuberculosis control activities, was also deemed necessary.

The committee's proposals were accepted with minor reservations by the Interim Commission, together with a number of specific recommendations as presented in the report on the first session of the committee.¹

At its second session, held in Geneva from 17 to 20 February 1948, the committee considered some of the problems discussed at its previous session, as well as a number of new questions, such as the medical examination of immigrants, a proposed conference on streptomycin, and the use of BCG vaccine.

In reconsidering some aspects of their discussion at the first session, the experts contemplated two types of fellowships to be granted by WHO: the first for senior workers for short periods of three to six months; the second for younger men of promise requiring at least a full year's training. Because of the limited number of fellowships now available, the committee recommended that priority should be given to the fellowships for senior workers. Governments should be impressed with the great advantages of releasing such men for these relatively short periods of time.

The question of immigration is now being considered by a committee of the Economic and Social Council of the United Nations. The committee emphasized that tuberculosis among immigrants was an international problem and that it was important for examinations to be made in the country of departure, such examinations, including chest radiography, to be interpreted by a medical officer acceptable to the government receiving the immigrant.

¹ Bull WHO 1948 2, 20.

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In reply to a request from UNICEF for periodic conferences on the application of tuberculin tests and BCG vaccine, the committee recommended that a small number of recognized specialists be asked to serve on a sub committee for this special purpose

The committee urged that the fight against tuberculosis was a task for the whole of humanity. The nations fortunate enough to be relatively healthy, inspired by intelligent self interest and humane considerations, will necessarily have to come to the aid of stricken nations, and through money, professional personnel and equipment distribute existing resources to the needy and suffering areas of the world

Co ordination of Medical Abstracting

One of the great problems confronting workers in nearly all branches of science is the ever growing flood of periodical literature. In this respect, medicine is one of the worst afflicted of the sciences. Up to a little more than a century ago, medicine was still largely a literary study and doctors have a centuries old tradition of exposing their views in books, pamphlets and periodicals. Apart from the effects of this tradition, medicine is a profession in which the opportunities for making original observations are not confined to a relatively few academic or industrial centres with well equipped laboratories. The great bulk of articles published in the medical Press still comes from men who are practising medicine, although a steadily increasing proportion represents the work of full time research workers. A stage was long ago reached when only the largest of medical libraries could afford to receive and house a representative selection of the world's medical journals.

One solution to this problem would be for medical men to publish less, for very many articles in medical journals are of doubtful or ephemeral value, or merely report slight variants of observations which have been published elsewhere. But there seems little prospect at present of a decline in the volume of medical publication. Rather does the contrary appear to be the case, for increasing specialization in medicine results in the appearance of new specialist journals, without a corresponding diminution of the volume published in pre existing journals.

As the number of medical journals increases, the need for abstracting services becomes greater, for only by consulting one or more

abstracting journals can many medical men—particularly those without access to good library services—hope to know what has been published with a bearing on the subjects in which they are interested

Before the war, the German Zentralblatter used to provide collectively a relatively comprehensive abstracting service in the German language, but libraries used to find the cost of subscribing to them unduly high. For tropical medicine and public health, the Bureau of Hygiene and Tropical Diseases has for many years provided in its two publications, the *Tropical Diseases Bulletin* and the *Bulletin of Hygiene*, a low priced abstracting service which, because of the fullness of the abstracts and the fact that they are all prepared by experts, has been invaluable to English reading medical workers in parts of the world which are remote from cultural centres. These two publications provide good examples of what has been called the informative (more properly, perhaps, substitutive) abstract. *Nutrition Abstracts and Reviews*, published by the Commonwealth Bureau of Animal Nutrition, provides a similar service for those interested in human and animal nutrition.

At the opposite end of the scale is the so called 'indicative' abstract, which is intended to indicate only the general scope and main conclusions of the original paper. An example of this type of abstract is to be found in *British Abstracts*, which has a physiological section published separately. The extreme of the indicative abstract is represented by the *Bulletin Analytique*, published by the documentation service of the Centre national de la Recherche scientifique in Paris. This has been described by its sponsors as containing 'expansions of the titles' of the original papers. *Biological Abstracts*, which is published in the United States of America and aims at covering biology and experimental medicine, is midway between the extremes of the informative and indicative types of abstract. It is distinguished from other abstracting services in that most of its abstracts are prepared by the authors of the original papers—a method which proves, under good management, satisfactory in relation to the more exact disciplines with which *Biological Abstracts* is concerned, but which would probably be unsatisfactory for the clinical branches of medicine.

Until recently, no concerted effort had been made to determine whether any of the medical abstracting services were unnecessarily overlapping, or whether there were branches of medicine which were not served at all. In 1946, however, it became clear that two new

English language abstracting services which had been announced might involve wasteful duplication of effort—both in regard to each other and also to some of the older abstracting services

One of these new services was *Excerpta Medica*, published in Amsterdam, and the other *Abstracts of World Medicine* and *Abstracts of World Surgery*, published in London under the general direction of the *British Medical Journal*

In June 1946, the Editor of the *British Medical Journal* drew the attention of the Preparatory Commission of UNESCO to the need for co ordinating medical abstracting services, and UNESCO arranged in the following December a meeting of representatives of *Excerpta Medica* and *Abstracts of World Medicine* at UNESCO House, Paris. A second meeting of the same parties, but including representatives of *British Abstracts*, was held in London in July 1947, and in October 1947 UNESCO convened a Conference on Co ordination of Medical Abstracting Services. These plans were made in consultation with the Interim Commission of WHO, and a WHO observer participated in the conference. At this conference, it was arranged that an Interim Co ordinating Committee on Medical and Biological Abstracting should be formed, and a meeting of this committee, attended by two WHO observers, was held in Paris on 5-6 April 1948. Dr Hugh Clegg, Editor of the *British Medical Journal* was elected chairman, and Mrs Eileen P. Cunningham, President of the Medical Library Association (USA), vice chairman. Other members of the committee were Mr F. Donker Duyvis (International Federation for Documentation), Dr G. M. Findlay (Editor, *Abstracts of World Medicine*), Dr L. Lampitt (*British Abstracts*), Dr F. H. Landshoff and Prof M. W. Woerdeman (*Excerpta Medica*), and Prof Samson Wright (*British Abstracts*). The committee gained much by the presence as observers of Dr L. J. Crane, Editor of *Chemical Abstracts* (Columbus, Ohio), and Prof V. Lander, of the Ingenjors Vetenskaps Akademien, Stockholm. Unfortunately, Dr John L. Flynn, of *Biological Abstracts*, Philadelphia was prevented by indisposition from attending.

At this meeting, matters of detail were discussed and some differences of opinion on broader issues were revealed. It has been agreed at an earlier informal meeting that effective collaboration could be obtained only as between non profit making organizations, and representatives of a new abstracting service which had been started on a profit making basis announced at this first meeting of the

Interim Co ordinating Committee that they had reorganized their service and applied for legal recognition as a non profit making body

Among the resolutions adopted at the April meeting were that WHO and FAO should be invited to join UNESCO in sponsoring the activities of the committee, that the following agencies should be invited to join the committee—Bureau of Hygiene and Tropical Diseases, Commonwealth Bureau of Animal Nutrition, a representative of French *medico biological abstracting*, the American Medical Association, *International Abstracts of Surgery*, *Chemical Abstracts*, that an executive committee should be appointed, and that the Control Commissions in Germany should be informed of the existence and objects of the committee in view of the possible resumption of German medical abstracting periodicals. Various other resolutions on matters of style and measures of co operation between abstracting services were also adopted

Thus an attack—not a major offensive, but a small local engagement—has been made on the vast and untidy problem of the rationalization of medical periodical literature. If useful work can be done on the co ordination of medical and biological abstracting, encouragement will perhaps be given to an inquiry into the possibility of reducing overlapping at the source

Towards the Co-ordination of Medical Congresses

Representatives of nine medical organizations¹ met on 12 April in Paris, under joint WHO UNESCO sponsorship, to formulate plans for a long needed co ordination of medical congresses

-
- ¹ Professor F BESANÇON, International Union against Tuberculosis
 Dr P CIBRIE representing Professor E MARQUIS, President of the World Medical Association
 Professor R DEBRÉ, International Pediatric Association
 Dr L DEJARDIN, International Society of Surgery
 Dr H HELMHOLTZ, International Pediatric Association
 Professor J MAININ, International Union against Cancer (Chairman)
 Dr R PETERSON, International Congress of Radiology
 Dr H Y SAUTTER representing Dr A CAVAILLON, International Union against Venereal Diseases
 Dr K SONN, representing Dr J R REES, International Congress on Mental Health
 Dr M P WEIL, International League against Rheumatism
 Professor A GIGON, International Society of Internal Medicine was unable to attend

Most of the international medical organizations have not been active for ten years, and many have no permanent organization in the period between the congresses. The need for a central organism to ensure continuity and co-ordination of the medical congresses is now apparent.¹

The three day session in Paris was entirely devoted to the outlining of plans for the establishment of a permanent bureau for the co-ordination of international congresses of medical sciences.

Principles of membership were tentatively laid down. Medical congresses of a broad international character are to be accepted as full members, those which have either a regional or a not strictly medical character are to be able to participate in the work of the permanent bureau as associate members.

The bureau's functions as outlined by the meeting will be as follows:

I Information and Assistance

- (1) to collect information on all national or international organizations of a medical or paramedical nature and on the congresses which they organize (present programme and as far as possible future programmes, dates, subjects studied, names of rapporteurs)
- (2) to give all material assistance in particular as regards specialized conference services (staff, technical material) and travelling facilities for congress members (visas, etc.)
- (3) to study methods facilitating the transfer of funds needed by congress members
- (4) to study the technique of holding congresses and give information regarding it

II Co-ordination

- (1) to suggest to international medical bodies appropriate dates and places for the holding of their congresses
- (2) to make a special effort to group disciplines together
- (3) to give financial assistance to the scientific work of congresses and make grants to congress members who particularly merit them
- (4) to give grants to enable invited representatives of other disciplines to take part in the congresses

¹ *Chronicle WHO* 1948 2, 38

III *Diffusion of Information*

- (1) to circulate information received from the various organizations of medical or paramedical nature
- (2) to study the whole problem of diffusion of medical information including the circulation of the proceedings of the congresses

An executive committee composed of six members was appointed to continue the work. Its task will be to draft statutes for the bureau, to collect information on all congresses and associations likely to be interested in its activity, to receive applications for membership, and to undertake the preparation of an international conference of all qualified organizations to meet at the earliest towards the end of 1948.

The group concluded its work by calling the attention of WHO and UNESCO to the urgent need for such a permanent bureau

NEWS FROM THE FIELD

Ethiopia

H I M Haile Selassie distributed certificates to the dressers trained by the WHO Mission at a ceremony at the Ministry of Health on 20 April. Nearly 100 dressers and 60 sanitary officers have now been trained and his Imperial Majesty's interest was greatly appreciated.

Dr V M Goodman, Director of Field Services, visited the Mission in Ethiopia from 9 to 18 March. In addition to questions of policy, programme, co-operation and finance to be discussed with the Ethiopian Authorities, many matters concerning the administration and staff of the mission had arisen since his last visit in March 1947.

Dr T Guthe, medical officer for venereal diseases, accompanied Dr Goodman and stayed five weeks to advise the Ethiopian Government at its request on the extent of venereal disease and possible ways of dealing with it.

Mr P Bierstein, a sanitary engineer loaned from the Greek Mission since October 1947 as deputy chief of the Ethiopian Mission, returned to Greece in April to assist Col Wright in the 1948 anti malaria campaign there. In Ethiopia Mr Bierstein was engaged in the training of sanitary officers and established small demonstration and training projects in Addis Abeba including mosquito surveys and spraying, and anti typhus dusting with DDT. Incidentally he developed as a teaching method the acting of playlets or imaginary scenes which was greatly appreciated by the Ethiopians. In one of these one student would play an irascible butcher and the other a sanitary officer without police powers wishing to inspect his meat.

Greece and Poland

On his return from Ethiopia Dr Goodman spent a week in Athens to renew contacts and discuss policy and mission problems with Dr J M Vine and the other staff of the Mission. Mr C Ashwin, consulting radiographer, left the Greek Mission in March on loan to Poland where a large programme of rehabilitation of x ray machines awaited him.

Italy

A week was also spent by Dr Goodman in Rome and included conferences with the staff of the Rockefeller Foundation engaged in the anti anopheline project in Sardinia. With Dr J Farfor, Chief of the WHO Mission to Italy, Dr Goodman was received in private audience by His Holiness the Pope; they explained the work of WHO and of its Italian Mission.

WHO PUBLICATIONS

Epidemiological and Vital Statistics Report

Vol 1, No 7, December 1947

World Distribution and Prevalence of Cholera in Recent Years

Dr Yves Biraud Director of Epidemiological and Public Health Statistics WHO Geneva and Dr P M Kaul Director of the WHO Epidemiological Intelligence Station Singapore discuss in Vol I no 7 of the *Epidemiological and Vital Statistics Report* the world distribution and prevalence of cholera in recent years

For the past thirty years cholera has been confined almost entirely to the continent of Asia. During the ten years preceding the second World War cholera affected Ceylon Burma Siam, French Indo China the Philippines the Netherlands Indies China, Japan Korea Afghanistan Iran and Iraq but the disease wrought the greatest havoc in India where the main epidemic foci were—and still are—located

Figures for British India which included before August 1947 some three fourths of the population of the country show that while the average yearly number of deaths from cholera was 444 000 in 1892 1896 only 135 000 were recorded yearly during the period 1932 1937. This represents an actual reduction of two thirds in the mortality or of three fourths if the considerable increase in the population between the two periods is taken into account

Comprehensive measures including compulsory inoculation of all pilgrims attending religious festivals have been more and more effectively enforced with the gratifying result that in recent years outbreaks of cholera in festival centres are becoming a rarity

However a setback occurred in 1939 when 236 000 deaths from cholera were recorded. The years 1939 and 1940 were years of very low incidence and the mortality from cholera was 97 566 and 86 133 respectively. Only twice before in 1932 and in 1933 had lower figures been recorded. In 1941 as a consequence of wartime difficulties such as shortage of medical personnel and of experienced public health officials most of whom were enrolled in the army 228 141 deaths from cholera occurred in British India. The year 1942 with 218 496 deaths from cholera showed the same epidemic prevalence. In 1943 epidemic conditions reached a climax. This was the year of the Bengal famine caused among other things by the advancing Japanese forces the flight of the population the destruction of the rich rice harvests and the cutting off of the large imports of rice. Cholera deaths during this year amounted to 459 930 a return to the level of incidence seen during the closing years of the last century

After 1943 there was a decline. However 1944 and 1945 were still heavy epidemic years with 294 525 and 278 507 deaths respectively and fair

ly widespread infection all over the country. Real improvement was effected only after the war. The mortality during 1946 was 76 352 during 1947 it was 82 699.

Figures for Burma, Siam, French Indo China, the Philippines, Japan, Korea and China, all of which became battlefields, show that they were all more or less affected during the second World War by the cholera epidemic. At the end of the war the epidemic showed a definite regressive tendency. Generally speaking for all Asiatic countries including India the year 1947 was comparatively favourable as regards cholera.

The second half of the article by Biraud and Kaul is devoted to an epidemiological description of the recent cholera outbreak in Egypt which has already been described at some length in this journal.¹

Statistical tables showing the morbidity and mortality for cholera and dysentery during the past three or four years complete this number of the *Epidemiological and Vital Statistics Report*.

Vol 1, No 8 January 1948

Recrudescence of Typhoid Fever in Europe

In an article which appeared in the *Epidemiological and Vital Statistics Report* Vol I No 8 Mr K. Stowman gives a general survey of the incidence of typhoid and paratyphoid fever in Europe in recent years.

A few years before the second World War there was a vast continuous zone extending over Northern, Central and Western Europe in which typhoid fever appeared to be waning. This zone included the United Kingdom, the three Scandinavian countries and Iceland, Germany, Switzerland and the Netherlands. In all these countries the incidence of the disease was less than 5 cases for 100 000 inhabitants and the mortality rate was well below 1 per 100 000. In many large cities outside this zone, such as Dublin, Helsinki, Brussels, Prague and Vienna, the typhoid fever death rates were also below 1 per 100 000. In Paris the death rate dropped to 1.3 per 100 000 in 1938.

Thus over 140 000 000 Europeans had less than one chance in 20 000 of contracting typhoid fever.

Outside this privileged area, Austria, Belgium, Finland, France, Ireland and Luxemburg with typhoid fever death rates varying between 1.2 and 3 per 100 000 inhabitants, were also in a fair way to inclusion in the area of safety.

In the countries east and south of these regions of slight and medium incidence, the number of cases rose steeply. In Poland there were still 50 and in Italy 70 cases per 100 000 inhabitants, to quote only two instances. But here too the rate of incidence on the whole showed a downward trend.

The second World War brought about a radical change in this favourable situation, and at present only the Scandinavian countries, Switzerland and the United Kingdom still show a low incidence. The flood of typhoid infection now laps at their borders without any protective area of medium incidence.

[¹ *Chronicle WHO* 1 141 173]

The figures for typhoid and paratyphoid show one peculiarity which is of some practical importance in every European country in the low incidence area paratyphoid especially of the B type is more frequent than typhoid. In all other countries with the exception of Finland typhoid is the more frequent.

A plausible explanation of this phenomenon is that the spread of typhoid fever in its epidemic form is more closely related to water supplies than that of paratyphoid. It is generally more difficult to trace and prevent contamination of food stuff than that of water and the milder disease is more liable to be overlooked than that which brings severe manifestations in its train. The case fatality rate for typhoid generally varies between 7 and 15 per cent while that for paratyphoid B nearly always remains well below 5 per cent indeed quite large outbreaks have occurred without a single death. This is why the incidence of typhoid fever was reduced faster than that of paratyphoid fever. Complete differentiation between typhoid fever and paratyphoid fever need of course an adequate system of public health laboratories and in view of the marked differences in the gravity as well as the general epidemiology of the diseases such distinction should be insisted upon wherever possible.

Nevertheless only a few countries have differentiated typhoid and paratyphoid fever in their reports during the ten years following the first World War and only Denmark has distinct figures up to the 1914-1918 War. In 1924 Finland began to provide separate information. Austria and Switzerland followed in 1926. A small number of other countries attempted to follow this example but their data relating to paratyphoid fever appear to be incomplete.

Diagram 1 and 2 indicate the trend of typhoid and paratyphoid fever for the past 20 years in a few countries selected because their frontiers have remained unchanged so that their data are homogeneous and more complete than those of other countries.

Diagram 1

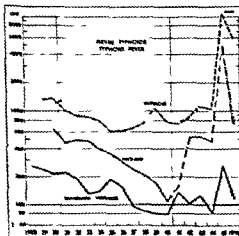
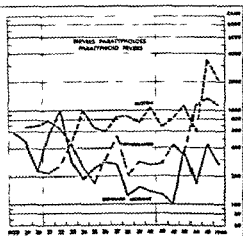


Diagram 2



An analysis of the returns from most European countries leads the author to conclude that the second World War like every other war in the past has caused an increase in the incidence of typhoid fever. As long as the sanitary services in most countries were regularly functioning—that is until the end of 1944—the increases were relatively moderate. In 1943 the number of typhoid fever cases reported from twelve continental countries was 55 per cent higher than the corresponding median for the years 1928-1938. In Germany as in France the incidence of typhoid fever in 1943 was about twice the pre-war median. This was a serious increase though in no way alarming. It was not until 1945 when destruction reached its peak and involved the collapse of all public services over wide areas that typhoid fever began to spread unhindered.

The post-war typhoid situation in Europe according to the author can only be regarded as most unsatisfactory. The safety area has narrowed down and now includes only the Scandinavian countries, Switzerland and the United Kingdom while the intensely infected area now extends from the Mediterranean to the southern coast of the Baltic and the North Sea. Typhoid fever which was definitely on the downward grade in an area containing about 200 000 000 inhabitants has now once more become a significant index of sanitary conditions. Although three years have elapsed since the end of the war there is unfortunately no sign as yet of a general downward trend in the incidence of this easily preventable disease.

Where typhoid fever is rare its transmission is due to accidental circumstances but where its incidence attains 100 cases or more for 100 000 inhabitants prevention is a matter of elementary sanitary engineering. In cases where lack of funds or of sufficiently co-ordinated effort still prevent the ensuring of safe water supplies mass vaccination could at any rate limit the outbreaks.

In Europe excluding the USSR there have been at least 250 000 cases of typhoid fever during each of the past two years which means an annual loss of some 25 000 human lives especially among the active age groups in addition to the loss of more than 5 000 000 working days. This is a factor of no mean importance in the planning of economic rehabilitation. It is disgraceful states Mr. Stowman in conclusion that such a situation should be allowed to persist when the means of remedying it are universally known and have been accessible for the past forty years or so.

This number of the *Epidemiological and Vital Statistics Report* also contains statistical tables showing the incidence of and deaths from typhoid and paratyphoid fever and similar data for undulant fever.

Official Records of WHO

The *Official Records* of WHO contains in two of its latest numbers the Interim Commission's report to the World Health Assembly.

This report falls into two parts. The first an account of the Commission's origin and of its work up to the present time constitutes No. 9 of the *Official Records*. Part II consisting of the provisional agenda for the Assembly with relevant documents and recommendations is contained

in No 10 The introductory section of the report a broad general survey of what the Commission has done will be reproduced from No 9 in the May number of the *Chronicle*

No 7 of the *Official Records* which will be published shortly comprises the minutes and documents of the fifth—and final—session of the Commission Others of the series to appear before the opening of the Health Assembly will be No 8 containing expert committees reports which were submitted to the fourth and fifth sessions of the Commission and No 2 devoted to the historic International Health Conference of June July 1946 which drew up the Constitution of the WHO and the other basic Acts

REPORTS FROM WHO FELLOWS

Many of the letters and reports received from WHO Fellows have been of such interest that they deserve to be read by a wider public They demonstrate more vividly than a series of facts and figures both the character of the fellowship programme and the response of the Fellows themselves Selections from these reports will therefore be published from time to time, but it must be emphasized that the opinions expressed are those of the Fellows

* * *

PUBLIC HEALTH IN SWITZERLAND

A STUDY TOUR BY AN AUSTRIAN FELLOW

Dr Franz Puntigam is Head of the Epidemiological and Statistical Division of the Public Health Department of the Federal Ministry of Social Welfare Austria He has recently spent four months as a WHO Fellow studying the organization of public health in Switzerland The following is a résumé of a comprehensive report which he has submitted on his tour

As health legislation in Switzerland is mostly on a cantonal basis Dr Puntigam decided to concentrate on the organization of public health in rural urban and mixed rural urban cantons—those of Basel Stadt Vaud Valais and Zurich—where he studied health centres sanatoria hospitals open air schools and sanitary engineering works

In the tuberculosis clinics he was impressed by the social welfare work and by the measures to prevent infection Each canton has a centre to deal

with patients in need of sanatorium treatment a system which considerably reduces the waiting period for admission. Mass radiography has reached a high degree of efficiency its practice being particularly well exemplified by the institution at Zurich. In the Zurich Oberland 58 per cent of the population has been examined by this method largely as a result of extensive propaganda through lectures pamphlets and other means. Three doctors including the radiologist and a tuberculosis specialist are normally attached to each unit. They discuss their findings with the patient's own general practitioner or his local tuberculosis clinician.

Among the many sanatoria he visited Dr Puntigam considered the most modern to be the Physikalisch Meteorologisches Observatorium at Davos. Most of the sanatoria are extremely well equipped although fluoroscopy is seldom employed. At some such as the Clinique Manufacture at Leysin and the Heilstätte Appenzelberg occupational therapy is practised in addition to general therapeutic methods. General scientific tuberculosis research is carried out by the Federal Public Health Bureau in co-operation with the Federal Veterinary Bureau. Dr Puntigam refers particularly to the valuable work done by Schaefer and Dubos on the culture of tubercle bacilli which should prove of great importance in the diagnosis of tuberculosis.

Most of the district hospitals he visited had been built during the 1930's usually on the block or the pavilion system or as in the new cantonal hospital at Zurich on a combination of the two. Even in these general hospitals he found a rigid separation of treatment blocks from those containing the wards and in smaller hospitals the operating theatres were always perfectly equipped. The general tendency was to avoid large wards and there were usually not more than eight beds to a ward.

The treatment of venereal diseases is mainly in the hands of cantonal and municipal authorities and of a private organization the Schweizerische Gesellschaft zur Bekämpfung der Geschlechtskrankheiten which educates the public by means of lectures films and pamphlets and supplies treatment free of charge to needy patients. Until the second World War there was little venereal disease in Switzerland but its incidence has since increased although not to any alarming extent. Exact figures are difficult to obtain as venereal diseases are not notifiable although a special Federal law prescribes compulsory notification of the source of infection. Hence many patients have remained without treatment but new legislation passed by the Federal Council in 1947 requires doctors to notify health authorities of any refractory patients.

Dr Puntigam was particularly interested in the open air school of Basel. This type of institution is fairly common and special conveyance is often provided for the children.

Prevention of goitre has always constituted a special problem in Switzerland. The deficiency of iodine in the drinking water has been remedied by the manufacture and sale under cantonal auspices of special iodized table and cooking salt. Over a period of twenty years this policy has yielded excellent results and has led to a better physical and mental development of children.

Disinfection and disinfection services are extremely well organized. Trimetholglycol is chiefly used in disinfection and in disinfection DDT has superseded most of the other insecticides.

An important feature in Swiss industrial life is SUVA (Schweizerische Unfallversuchsanstalt)—a service for the prevention of accidents. All plans and drawings for new machinery are submitted to this agency whose engineers study them and advise improvements where necessary. SUVA inspectors regularly visit all factories and supervise the operation of machinery and safety devices. Although SUVA has its own medical service which devotes particular attention to research on silicosis it is responsible chiefly for the prevention of accidents; the medical service attached to the Federal factory inspectorate being responsible for general industrial hygiene.

In conclusion the author points out that in his report he has confined himself to describing and evaluating such Swiss institutions as might be of interest to his own country. While his tour did not suggest to him any fundamental changes in the Austrian health administration as set up in 1929 he feels that there is a need for reorganization of personnel, material and equipment. As Austria has been since 1938 virtually isolated from international scientific contacts there is still a great need for medical literature to cover that period and he suggests specifically the bringing up to date of the library of the Austrian Public Health Department. He also recommends the creation of sanitary inspectors' posts in the public health service; the responsibilities of such officials to include housing, disinfection and disinfection. He urges early attention to the revision of legislation on the medical auxiliary professions and to the extension of biological research laboratories and tuberculosis sanatoria. Finally he advocates the setting up—as was done in Switzerland with great success during the war—of an organization to control foodstuffs and test them for purity and food value.

NOTES AND NEWS

WHO Representation

During the period between 12 March and 20 April the Interim Commission was represented by observers who attended or took part in the meetings of the following organizations

Technical *ad hoc* Committee on Housing Lake Success 30 March

Seventh Session of the Executive Board of UNESCO Paris 2 April

Second Session of the Council of FAO Washington D C 5 April

Interim Co ordinating Committee on Medical and Biological Abstracting UNESCO Paris 5 & April

Expert Committee on Scientific Abstracting UNESCO Paris 7 & April

Preparatory Meeting on Co ordination of International Congresses on Medical Sciences UNESCO WHO Paris 12 April

Recent and Forthcoming Meetings

10 May 18 May Consultation of Plague Experts Washington D C

19 May 25 May Expert Committee on Malaria Washington D C

31 May 5 June Expert Committee on the Unification of Pharmacopœias Palais des Nations Geneva

15 June 16 June Expert Sub Committee on BCG and Tuberculin Paris

24 June First World Health Assembly Palais des Nations Geneva

30 July 31 July Expert Sub Committee on Streptomycin New York

Corrigendum

Footnote 1 page 4 Volume II of the *Chronicle* should read Additional sums bringing the total to 200 000 U.S.A. dollars were transferred from the Mission operations budget during 1947 thus making available additional fellowships

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

VOL II, No 5

May 1948

WORK OF THE INTERIM COMMISSION

United Nations organize for World Health

The basic importance of health in the promotion of conditions of stability and well being was recognized at the United Nations Conference in San Francisco, 1945, which therefore included health among the subjects of co operative endeavour with which the United Nations should be concerned

At this conference, approval was given to a declaration, proposed by Brazil and China, calling for an international conference to establish an international health organization

The San Francisco declaration was implemented by the United Nations Economic and Social Council, which, soon after its establishment, passed a resolution to call an international health conference

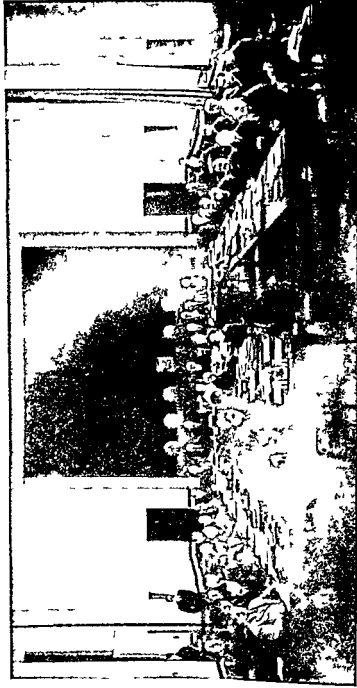
The International Health Conference was preceded by a Technical Preparatory Committee of experts, which met in Paris from 18 March to 5 April 1946 and prepared a draft constitution From this preparatory meeting, there came forward several important concepts These were that

the new health organization should be a single specialized agency with a high degree of independence
that

medical science is going through a period of fundamental change new needs are coming to light and it is for the organization to meet these needs and even to anticipate them
and that

it is desirable that the organization include as many member States as possible and aim at becoming universal

Second Session of the Interim Commission



From left to right sitting at the main table Dr G H de Paula Souza Dr Szeming Sze Dr A Cavallion Dr J N Togba
Dr C van den Berg Dr Melville D Mackenzie Dr A Gabaldón Dr D Curnel Dr D Juzbašić Dr A J Lucas,
Mr G F Yates Dr A Stampar (Chairman) Dr Brock Chisholm (Executive Secretary) Dr Y M Birau (Secretariat)
Dr T Larran, Dr E Krotkov Dr K F'vang Dr M Martínez Baez Dr C Mani Dr A T H'au ley

The International Health Conference, which opened in New York on 19 June 1946,¹ was the first conference to be called by the United Nations. Fifty one nations were represented with voting rights, and thirteen were represented by observers.

The conference decided to take steps to absorb the Office International d'Hygiène Publique, requested the Secretary General of the United Nations to make the necessary arrangements for transferring the League of Nations Health Organization's functions, and agreed that the Pan American Sanitary Organization was to be integrated with the World Health Organization through common action based on mutual consent. The greater part of the conference was devoted to the drafting and approving of the Constitution of the World Health Organization, - which was signed by the 61 nations represented.

Establishment of the Interim Commission

Before, however, the Constitution of the World Health Organization could enter into force, it would have to be ratified by at least 26 member States of the United Nations. It was therefore decided that, until then, an interim commission should be established which would be concerned mainly with preparatory work for and establishment of the organization, continuation of the functions of former international organizations, and, if necessary, assistance in the solution of urgent health problems.

Eighteen countries were elected to membership of the Interim Commission of the World Health Organization: Australia, Brazil, Canada, China, Egypt, France, India, Liberia, Mexico, the Netherlands, Norway, Peru, the Ukrainian SSP, the USSR, the United Kingdom, the United States of America, Venezuela and Yugoslavia.

It was originally expected that the Commission would not remain in being for more than a few months. However, the unexpected happened, and delayed ratifications prolonged its life to almost two years. The Commission was accordingly faced with many important technical problems which could not await the establish-

¹ For a fuller account of the work of the Technical Preparatory Committee and of the International Health Conference see *Chronicle WHO* 1947 1 1.

² See *Chronicle WHO* 1947 1 29 for the Constitution of WHO.

A high-contrast, black and white photograph showing a large crowd of people gathered on a street, possibly for a protest or demonstration. The crowd is dense, and many individuals are looking towards the camera. The background shows a building with a sign that reads "HOTEL". The image is oriented horizontally on the page.

From left to right sitting at the main table Dr G H de Paula Souza Dr Szmung Sze Dr A Cavaillon Dr J N Togba
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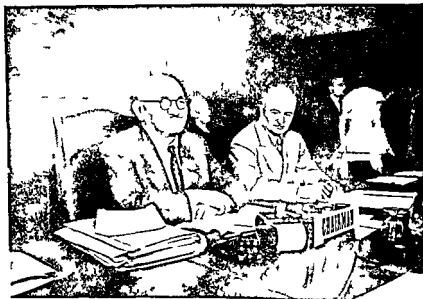
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² See *Chronicle WHO* 1947, 1, 29 for the Constitution of WHO.

ment of the permanent organization, but, in spite of initial handicaps, a large variety of technical subjects was successfully dealt with and a firm foundation was laid for the handling of many urgent health problems

A choice of problems had to be made, separating those which could await the formation of the permanent organization from those which were too pressing to permit of further delay. Moreover, in the selection of problems for immediate attention, the Commission had to consider not only their urgency and importance,



Dr. A. Stampar, Chairman of the Interim Commission
and Dr. Brock Chisholm, Executive Secretary

but also the extent to which available resources made it feasible to initiate effective action. It was also necessary to adjust the work of the Commission to the complex framework of the United Nations and its councils, commissions and specialized agencies, and of other official and voluntary bodies.

In all the Interim Commission held five sessions. The first opened in New York, towards the end of the International Health Conference. Dr. F. G. Krotkov, Deputy Minister of Public Health

of the USSR, who was elected Chairman, was unable to continue as such owing to the pressure of other duties. He was succeeded by Dr. Andrija Stampar, Professor of Public Health and Social Medicine at the University of Zagreb, who held the office for the remainder of the Commission's existence. As Executive Secretary, the Commission elected Dr. Brock Chisholm, Deputy Minister of National Health and Welfare of Canada.

The four remaining sessions were held in Geneva at intervals of about four months.

For the execution of the Commission's tasks, an adequate administrative machinery was the first essential. A competent staff had to be found and appointed, a plan of activities had to be framed, and budgets had to be prepared.

The Machinery

The Commission's work was carried out largely through five internal committees.³ Budgetary and staff matters were the responsibility of the Committee on Administration and Finance, which was advised by a special Sub-committee on the Field Services Budget on the best way of allocating funds received from UNRRA.

Administration and Finance

It was to the Committee on Administration and Finance that the work of preparing the budgets for 1946-1948 was entrusted, as well as the proposed budget for the first year of activity of the permanent organization. The sum budgeted for 1948 was slightly over 3 million dollars, while the budget proposed for 1949 for the permanent organization amounted to \$6,324,700. During the life of the Commission, funds were obtained from three sources—as loans from the United Nations, as funds transferred from the Board of Liquidation of the League of Nations, and, in respect of field services, as grants made by UNRRA, and in submitting its budget proposals to the Health Assembly, the Commission had to take into account the obligation to repay the sums obtained from the first of these sources. It was decided that provision for repayment of the United Nations loans should be made in a budget for the period of 1948 following the establishment of WHO.

³ For the membership of these committees see *Chronicle WHO* 1947
1 54 93

Fifth Session of the Interim Commission



From left to right sitting at the main table
Dr A Stampar (Chairman) Dr G Stuart (Secretariat) Dr Y M Biraud
(Secretariat) Miss Mary Isaeva (interpreter) Dr W Vinogradov Dr H
van Zile Hyde Dr W Aeg Timmerman Dr C Banning

It was natural that the Commission should at first be largely dependent on the United Nations for its personnel and administrative services, and that it should have been guided by United Nations precedents in regard to staff and financial regulations and procedures. It was soon necessary, however, to make considerable increases in the small staff with which the Commission had started and in some cases it was possible to recruit experienced personnel from the pre-existing organizations which had been assimilated.

The bulk of the Commission's functions was concentrated in Geneva. The headquarters office in New York maintained liaison with the United Nations and with other agencies, and supervised the Commission's accounting and financial procedures. The New York office also took responsibility for public information and for the administration of field services in the Far East, and of fellowships awarded and materials procured in America.

In the appointment of staff, due regard had to be paid to equitable distribution by nationality. Between the second and the fifth

sessions, the staff grew to a total of nearly 200, distributed between the New York and Geneva offices, the Singapore Station, and the field missions. Yet even this number was not at times adequate to deal with the growing volume of work.

Relations

The study of the relationships that should be established and of the degree and kinds of co-operation that should be effected with the United Nations and its specialized agencies⁴ and with non-governmental organizations⁵ was one of the special tasks of the Committee on Relations. This work was not of purely administrative significance. Many international bodies had a direct or indirect interest in health and medical science, and it was important that the field of activities of the World Health Organization should be so delineated as to render it an effective instrument for pursuing the aims embodied in its constitution. Special sub-committees were sometimes appointed to carry on negotiations, as in the case of the United Nations itself and some of its specialized agencies. This aspect of the Commission's work reached final expression in the preparation of draft agreements for consideration by the first World Health Assembly.⁶

It was also to the Committee on Relations that the Commission delegated the work of studying and advising on the form of relations with the Pan American Sanitary Organization and the Sanitary Bureau at Alexandria, and with the Office International d'Hygiène Publique.

Technical Questions Headquarters Priorities

The most urgent of the Commission's duties were to carry on the functions of previous international health organizations and to take action on pressing health problems. For guidance on the technical implications of these duties, the Commission appointed a Committee on Epidemiology and Quarantine. The title of this

⁴ See *Chronicle WHO*, 1947 1, 69 for a chart of the structure of the United Nations, the Economic and Social Council and the specialized agencies; see also pp. 107-108.

⁵ The criteria recommended by the Interim Commission for the selection of non-governmental organizations eligible to be brought into relationship with WHO will be found in *Chronicle WHO* 1948 2 41.

⁶ *Chronicle WHO* 1947 1 45-50, 133; 1948 2 40.

Fifth Session of the Interim Commission



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Field Mission to Ethiopia



WHO school for sanitary engineers

Léon Bernard Arrangements were made to use the health and medical sections of the League's library, pending a decision of the United Nations on the transfer of ownership to the permanent organization. Later, other health functions of the League which had been suspended during the war were resumed by the Commission.

The remaining international health agency to be superseded by the Commission was the Health Division of UNRPA, which, in addition to its rehabilitation work in war devastated areas, had temporarily assumed responsibility for the essential work of administration of the international sanitary conventions and of epidemiological notification. These latter functions were transferred to the Commission on 1 December 1946—a month before the Commission took over the functions of OIHP. A few days later, the Commission signed an agreement by which it became responsible for most of the field service work of UNRPA's Health Division, UNRPA providing a grant of \$1,500,000 to finance the work in 1947. Coun

committee was later broadened to Committee on Technical Questions, with a corresponding extension of its terms of reference.

For examination of the question of the permanent seat of WHO the Commission appointed a Committee on Headquarters, which prepared a report embodying the results of studies on New York, Geneva, Paris and the United Kingdom as possible sites. This report was approved by the Commission for submission to the first Health Assembly.

Finally, a Committee on Priorities was appointed to give advice on the relative amount of attention to be given to various problems which continued to arise during the extended life of the Commission.

Assimilation of Earlier International Health Organizations

In accordance with the duties laid upon it, the Commission early took steps to assume the functions of the three earlier international health organizations—the Office International d'Hygiène Publique (OIHP), the Health Organization of the League of Nations, and the Health Division of UNRRA.

To facilitate the transfer of functions from OIHP a special sub-committee on negotiations was appointed, and within a few months the epidemiological and advisory work of OIHP had become the responsibility of the Commission and the notifications previously issued by OIHP were incorporated by the Commission in the *Weekly Epidemiological Record*. Responsibility for dealing with various technical questions and for publishing information hitherto included in the *Bulletin mensuel* of OIHP was also accepted and preliminary arrangements were made for taking over its library and archives. The Commission also agreed to undertake the administration and investment of the pension fund of OIHP. By February 1948, the duties and functions of OIHP had passed to the Commission, although its assets could not be taken over until the termination of the Rome Agreement of 1907.

Less than four months after its appointment, the Commission had taken over the functions of the Health Organization of the League of Nations and continued without interruption its epidemiological notification services and its work on biological standardization. The Commission also took over the League's Eastern Bureau at Singapore, as well as certain of its assets, and made plans for the eventual transfer of the Darling Foundation and the Fonds

The Commission accordingly appointed an Expert Committee on International Epidemic Control, giving it a mandate to propose a complete revision of international sanitary legislation. As the revision of the conventions by UNPPA in 1944 had not taken into account the provisions relating to the Mecca pilgrimage, an Expert Sub committee for the Revision of the Pilgrimage Clauses was appointed to make appropriate recommendations, and this sub committee prepared a report and a new draft text relating to the sanitary control of the pilgrimage⁹

The need to establish international agreement on technical problems was not limited to those fields in which the Commission had statutory obligations. The work of the Health Organization of the League of Nations in establishing international biological standards had come to an end during the war. In the meantime,

Field Mission to Greece



X ray examination centre

⁹ See *Chronicle WHO* 1947 1 88

tries which had formerly received aid from UNRRA were thus enabled to obtain from the Commission continued assistance, in the form of field missions, fellowships and other services, in building up and restoring their medical and public health services. For this purpose, a Field Services Division was created in the Secretariat. Later, a second grant of \$1,500,000 was received from UNPPA as a result of the extension of the Commission's life.

It was clear that further work of the same kind would be necessary when the permanent organization came into being, and that assistance would be required by other countries which had not been eligible under the terms of the agreement with UNRRA. The Commission therefore included in its recommendations to the first Health Assembly provision for aid to governments in the form of missions, fellowships, visiting experts and lecturers, supplies of medical literature and teaching equipment, and certain other emergency services.

In April 1948, UNRRA authorized the transfer from its funds of \$1 000,000 to help meet any need of the permanent organization for hard currency through mid 1949, it was understood that any uncommitted balances would be returned to UNRRA.

Special Health Problems

To assist in the discharge of its inherited statutory function of administering the international sanitary conventions, the Commission appointed an Expert Committee on Quarantine.¹ Later a panel of experts was appointed to advise on yellow fever.

The Commission believed however, that much more than the administration of existing conventions was required, and that the entire field of international epidemiological control should be re-examined in the light of modern scientific knowledge, although the conventions had, as an emergency measure, been revised by UNRRA as recently as 1944. It therefore set itself the task of formulating a uniform code of sanitary regulations, as visualized in Article 21 of the WHO constitution.² Such regulations, becoming automatically binding on all countries which did not lodge an objection within a stated period would avoid the delays consequent on the necessity of separate ratification of conventions by each country.

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² *Ibid* 1947 1 122

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Field Mission to Greece



X ray examination centre

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new biological products had been developed and the need for international units of potency was urgent. Early in 1928 the Commission decided to resume and extend this work by the appointment of an Expert Committee on Biological Standardization. In two sessions this committee adopted new international standards for penicillin, heparin and vitamin E, and made studies and recommendations on a wide variety of essential therapeutic, diagnostic and diagnostic agents of animal and plant origin: diphtheria and tetanus toxoids, cholera vaccine, tuberculin, streptomycin and the human blood group substances.¹⁰

It was not only in respect of biological products that an agreement was necessary. Many potent new chemical drugs were being made available and it was becoming increasingly clear that rules of nomenclature and dosage should be the same in all countries and that international authority should be exercised in establishing such uniformity. As a collateral activity to its work on biological standardization the Commission therefore began preliminary work on the unification of pharmacopoeias, a continuation of the earlier work of the League's Technical Committee of Pharmacopoeial Experts.

An expert committee was appointed, which divided all drugs in common use into three categories: those requiring immediate consideration, those which would require attention at a later stage, and those which could be disregarded. As an ultimate solution to the problem arising from differences in national usage the Commission recommended to the first Health Assembly the preparation of an international pharmacopoeia.¹¹

Medical aspects of the control of narcotics and other habit-forming drugs presented a related problem. The transfer of the national control of such drugs from the League of Nations to the United Nations imposed technical and administrative problems on the Commission for which it was necessary to set up a special Committee on Habit-forming Drugs. The task of this committee was to study such regulations becoming necessary, as visualized by the Commission, which did not lodge an objection to the delays consequent on the necessity of convening by each country

¹⁰ An account of the work of the Commission is given in the

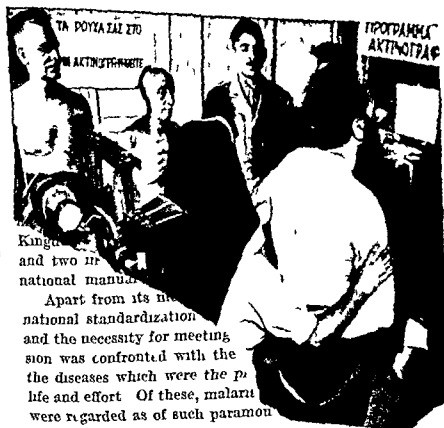
¹¹ See *Chronicle of the League of Nations*, 1928, 146.

¹² *Ibid.* 1947, 1, 122.

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Field Mission to Greece



Kingdom
and two in
national manual

Apart from its need for international standardization and the necessity for meeting the situation was confronted with the the diseases which were the problem of life and effort. Of these, malaria were regarded as of such paramount

cases
establish

³ See *Chronicle WHO* 1947, 1, 84-162

ment of expert committees could not be deferred. The work of these committees was essentially to advise the Commission on the broad strategy of the respective problems and to assist in the framing of recommendations for action by the permanent organization.

The Expert Committee on Malaria was later asked by the Commission to advise on a general plan for the world control of malaria as well as on such specific problems as the use of insecticides and chemotherapeutic drugs¹⁴. The work of the expert committees on tuberculosis¹⁵ and venereal diseases¹⁶ followed essentially similar lines, including general assessments of the possibilities for international action in the light of scientific advances, as well as recommendations in relation to specific technical matters.

The Commission recognized the great importance of undertaking work on the problems of maternal and child health,¹⁷ and

Expert Committee on Malaria



From left to right: Dr E Pampana (secretary), Dr M Ciuca (Roumania), Dr A Gabaldon (Venezuela), Dr P F Russell (United States), Dr N Hamilton Fairley (United Kingdom).

¹⁴ See *Chronicle WHO* 1947 1 101

¹⁵ *Ibid* 1947 1 151 1948 2 57

¹⁶ *Ibid* 1948 2 15

¹⁷ *Ibid* 1948 2 39

it was decided accordingly that assistance and services should be given to the United Nations International Children's Emergency Fund, which was in a position to take immediate action¹⁸ Technical support was given to UNICEF's campaign of mass inoculation with BCG, and the Commission appointed a pediatrician to work with UNICEF and also a full time medical officer as adviser in public health and as liaison officer Further, the Commission joined with FAO in forming a committee on child nutrition to advise UNICEF, which used the committee's report as a basis for its child feeding programme¹⁹

An opportunity of testing the effectiveness of international measures for the control of an outbreak of disease in a particular country was given to the Commission by the Egyptian cholera epidemic of 1947²⁰ In addition to the essential services of notification performed, the Commission undertook the bulk ordering of cholera vaccine and other supplies from many different sources, thus effecting a substantial reduction in the cost to the Egyptian and other Governments Lack of uniformity in batches of cholera vaccine from different sources, and infringement of sanitary conventions during the epidemic by several countries, presented the Commission with further problems urgently requiring solution

The Commission also undertook preliminary work on a number of other subjects, in some cases appointing expert members to the Secretariat to make inquiries and studies Information was collected on the world supply of insulin with a view to estimating the extent to which present and future demands could be met²¹ Arrangements were made for the establishment of an international influenza centre,²² and preliminary surveys on alcoholism and public health services were undertaken The Commission also agreed to co operate in the preparation and publication of the *Annual Report on the Results of Radiotherapy in Cancer of the Uterine Cervix*²³ and, at the request of the Venezuelan Government, to give technical advice in relation to the medical examination of immigrants²⁴ In response to a

¹⁸ See *Chronicle WHO* 1948 2 34

¹⁹ *Ibid* 1948 2 6

²⁰ *Ibid* 1947 1 141 157

²¹ *Ibid* 1948 2, 53

²² *Ibid* 1947, 1 124 1948 2 44

²³ *Ibid* 1948 2 32

²⁴ *Ibid* 1947 1 131

request from the United Nations Secretariat for co operation in the preparation of a report on the prevention of crime and the treatment of offenders, the Commission made available the services of a consultant psychiatrist to the Social Commission of the Economic and Social Council ²⁵

Malaria control in Italy



Spraying the walls of a house with DDT

General Services provided

In addition to the notification services assimilated from pre existing organizations, and the special services undertaken during the cholera epidemic the Commission provided certain general services applicable to a multitude of subjects. Of these by far the most important were the missions ²⁶ liaison officers fellowships,²⁷

²⁵ See *Chronicle WHO* 1947 1 132

²⁶ *Ibid* 1947 1 173 173

²⁷ *Ibid* 1947 1 75 114 1948 2 3

visiting lecturers²⁸ and experts, and medical literature and teaching material provided in the field services programme. By April 1948, 250 fellowships of an average duration of six months had been awarded, most of them in public health or clinical subjects. Fourteen countries had received one or more of the forms of service provided for in the programme.

Another service undertaken by the Commission was the publication of several journals for the dissemination of scientific, legislative and general information.²⁹ The *Bulletin of the World Health Organization* was designed to incorporate features both of the bulletin of OIHP and that of the Health Organization of the League of Nations. Material on sanitary legislation was published by the Commission as the *International Digest of Health Legislation*. For the general information of the medical and other interested professions the Commission published the *Chronicle of the World Health Organization*, a month by month account of its activities. The *Weekly Epidemiological Record* was continued in a modified form, and a monthly supplement the *Epidemiological and Vital Statistics Report*, was published.

In planning this service, the Commission attempted to provide only for the most essential needs without attempting to anticipate the views of the first Health Assembly on a definitive publishing programme. The attempt was also made to create a solid basis for the special library and reference services that would be required by the permanent organization, and a start was made with the provision of public information by Press, radio and film.

Final Task

When it became clear that the coming into effect of the Constitution of the World Health Organization would not be much longer delayed, the final task of preparation for the first World Health Assembly remained to be undertaken by the Commission. At its last session it decided to convene the Assembly on 24 June 1948. Under the terms of the Arrangement of 22 July 1946, the Commission was obliged to submit to the Assembly an account of its stewardship and also a provisional agenda complete with necessary documents and recommendations. It was decided that the documents

²⁸ See *Chronicle WHO* 1947 1 113

²⁹ *Ibid* 1947 1 83



Lectures given by a nurse of the Mission to students attending a three month course in tuberculosis nursing at the Sotiria Sanatorium

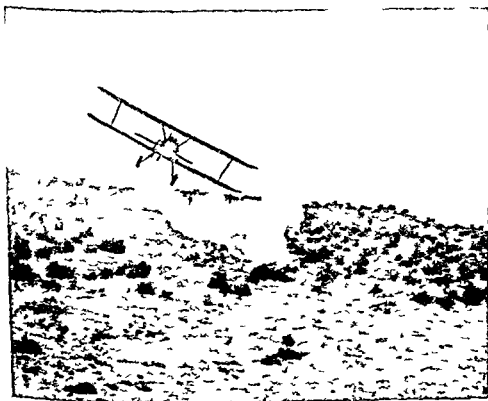
called for should be presented as two parts of a report, part I of which would be a general account of the Commission's activities, while part II would contain the detailed proposals to be considered by the Assembly

In making these proposals, the Commission recognized that the permanent organization would hardly be in a position during the first full year of its existence to develop definitive programmes for all the important health matters requiring international action. Special emphasis was therefore given to malaria, maternal and child health, tuberculosis and venereal diseases. The Commission also proposed a number of other subjects for action, and recommended that particular attention be given to alcoholism, drug addiction,

hygiene of seafarers, influenza, nursing nutrition rural hygiene, and schistosomiasis. Provision was made for continuing the essential work of earlier international health organizations which had now been superseded, and for maintaining the special and general services which would be indispensable to the new organization. The Commission's final task was not limited to the outlining of a programme, for it had also to consider and prepare detailed recommendations on the machinery by which such a programme would be implemented.

Proposals were accordingly made for the staff that would be necessary, and draft staff and financial regulations were prepared. Budget proposals for the year 1949 totalling nearly \$6,500,000 were submitted, together with draft agreements with the United Nations and certain of its specialized agencies, and a statement of principles involved in the establishment of relations with non

Field Mission to Greece



A plane spraying DDT on a swamp near Thebes

Field Mission to Greece



Lectures given by a nurse of the Mission to students attending a three month course in tuberculosis nursing at the Sotiria Sanatorium

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TABLE I

ATTENDANCES AT SESSIONS

Australia

- Sir Raphael Cilento, Director-General of Health and Medical Services
State of Queensland
- Mr. A. H. Tange, First Secretary, Australian Mission to the United
Nations, New York, United States of America
- Mr. G. M. Redshaw, Chief Medical Officer, Australian House, London
United Kingdom
- Mr. A. H. Bay, Third Secretary, Australian Mission to the
United Nations, New York, United States of America. *Adviser*

Brazil

- Dr. G. H. de Paula Souza, Director, Faculty of Hygiene and Public
Health, University of São Paulo

Canada

- Dr. Brock Chisholm, Deputy Minister of National Health, Ottawa
- Dr. T. C. Routley, General Secretary, Canadian Medical Association,
Toronto. *Absent during third and fourth sessions*
- Hon. Brooke Claxton, Minister of National Health and Welfare, Ottawa
- Dr. G. D. W. Cameron, Deputy Minister of National Health, Ottawa
- Dr. F. W. Jackson, Deputy Minister, Department of Health and Public
Welfare, Province of Manitoba
- Dr. H. A. Ansley, Assistant Director of Health Services, Depart-
ment of National Health and Welfare, Ottawa. *Adviser*
- Mr. J. Chapdelaine, Secretary, Canadian Embassy in Paris,
France. *Absent*
- Dr. J. A. McFarlan, Chief Medical Officer, Department of Health
and Social Services, Province of New Brunswick. *Adviser*
- Dr. M. R. Bow, Deputy Minister, Department of Health and
Public Welfare, Province of Alberta. *Adviser*
- Dr. L. Gerin Lajoie, Professeur et Vice-Doyen, Faculté de Méde-
cine, Université de Montréal. *Adviser*
- Mr. J. G. H. Halshead, Foreign Service Officer, Department of
External Affairs, Ottawa. *Adviser*
- Dr. E. Couture, Director, Division of Child and Maternal Health,
Department of National Health and Welfare, Ottawa. *Adviser*

China

- Dr. J. K. Shen, Deputy Director-General, National Health Adminis-
tration, Nankong

governmental international organizations. Studies were also submitted on the location of the headquarters of the permanent organization. The question of adjusting regional organizations to geographical areas was discussed, and recommendations were made on collaboration with the Economic and Social Council, UNICEF, and other United Nations bodies.

Finally, the Commission recommended the adoption of regulations and rules of procedure for the Health Assembly and for the expert advisory committees to be appointed by WHO, and the acceptance of a draft resolution on its own dissolution.

Mexico (contd)

Dr M Martinez Baez Permanent Representative of Mexico to UNESCO
Paris, France

Dr M Bustamante Research Epidemiologist Institute of Health
and Tropical Medicine Mexico City D.F. *Adviser*

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Dr W Aeg Timmerman Director Rijks Instituut voor de
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Dr C Banning Chief Medical Officer of Health The Hague
Alternate

Mr C J Goudsmit Legal Adviser Ministry of Social Affairs
The Hague *Adviser*

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Dr H T Sandberg Department of Public Health Oslo *Alternate*

Dr I Bjørnsson Chief Section for Epidemiology and Hygiene
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Dr N Baran Vice Minister of Public Health Kiev

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Dr Melville D Mackenzie Principal Medical Officer Ministry of Health
London

Sessions
attended

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- 1 2 3 4 5 Dr Szeming Sze Resident Representative Chinese Ministry of Health
Washington D C United States of America *Alternate* during
fourth session
- 4 Dr P Z Kiang Vice Minister of Health Nanking
- 3 Dr T L Su Technical Expert National Health Administration
School of Pathology University of Oxford United Kingdom
Alternate

Egypt

- 1 2 3 4 5 H E Dr A T Shousha Pasha Under Secretary of State Ministry of
Public Health Cairo

France

- 1 2 4 Dr Y Leclanche Inspecteur général de la Santé Ministère de la Santé
publique et de la Population Paris *Alternate* during second fourth
and fifth sessions
- 1 Professeur J Parisot Professeur d Hygiène Faculté de Médecine de
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- 2 3 4 5 Dr A Cavaillon Directeur général de la Santé Ministère de la Santé
publique et de la Population Paris
- 2 3 Dr H Y Sautter Médecin Inspecteur de la Santé Ministère de
la Santé publique et de la Population Paris *Alternate*
- 4 5 Médecin Général Inspecteur M A Vauzel Directeur du Ser
vice de Santé colonial au Ministère de la France d Outre Mer
1 ans *Alternate*
- 2 4 5 Dr L Bernard Chef du Bureau d Epidémiologie Ministère de la
Santé publique et de la Population Paris *Adviser*
- 3 4 Mme C Labeyrie Chef de Bureau Ministère des Affaires étran
gères Paris *Adviser*
- 5 M R Bollecker Administrateur civil au Ministère des Finances,
Paris *Adviser*
- 5 Dr G Montus Médecin Inspecteur divisionnaire de la Santé
Marseille *Adviser*

India

- 1 Lieutenant colonel C K Lakshmanan All India Institute of Hygiene
and Public Health Calcutta
- 1 2 3 4 5 Dr C Mani Deputy Director General of Health Services Government
of India New Delhi *Alternate* during first session

Liberia

- 1 2 Dr J N Togba Acting Director of Public Health and Sanitation
Monrovia
- 1 Dr J B West Director U S Public Health Service Mission to
Liberia Monrovia *Adviser*

Mexico

- 1 Dr O S Mondragón Under Secretary Ministry of Public Health and
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Dr B Vasilief Assistant in the Institute of Medicine Moscow
Adviser

United Kingdom

Dr Melville D Mackenzie Principal Medical Officer Ministry of Health
London

Sessions
attended

United Kingdom (contd)

3	Sir Wilson Jameson	Chief Medical Officer	Ministry of Health	London
1	Mr G E Yates	Assistant Secretary	Ministry of Health	London
		<i>Alternate</i>		
2	Mr L M Feery	Principal General Register Office	London	
		<i>Alternate</i>	<i>Adviser during fifth session</i>	
23	Dr W H Kauntze	Chief Medical Adviser	Colonial Office	London
		<i>Alternate</i>		
4	Dr A M W Rae	Deputy Medical Adviser	Colonial Office	London
		<i>Alternate</i>		
2	Mr R Brain	Principal	Ministry of Health	London
		<i>Adviser</i>		
2345	Mr C H K Edmonds	Assistant Secretary	Ministry of Health	London
		<i>Adviser</i>		
2	Dr Percy Stocks	Chief Statistician (Medical)	General Register Office	London
		<i>Adviser</i>		
2	Mr F A Vallat	Assistant Legal Adviser	Foreign Office	London
		<i>Adviser</i>		
4	Mr M E Bathurst	Foreign Office	London	
		<i>Adviser</i>		
4	Miss K V Green	Ministry of Health	London	
		<i>Adviser</i>		

United States of America

124	Dr T Parran	Surgeon General	U S Public Health Service	Washington DC
12345	Dr H van Zile Hyde	Senior Surgeon	U S Public Health Service	Washington DC
		<i>Alternate during first second and fourth sessions</i>		
12	Dr J A Doull	Chief Office of International Health Relations	U S Public Health Service	Washington DC
		<i>Adviser</i>		
1	Dr L B Williams Jr	Medical Director	U S Public Health Service	Washington DC
		<i>Adviser</i>		
24	Mr H B Calderwood	Consultant	Office of International Health Relations	U S Public Health Service
		<i>Adviser</i>	Washington DC	
3	Mr L W Hayes	Specialist	Division of International Organization Affairs	Department of State
		<i>Adviser</i>	Washington DC	
34	Mr S T Parcelman	Chief International Organizations Branch	Office of Budget and Finance	Department of State
		<i>Adviser</i>	Washington DC	
5	Dr Martha M Ehot	President	American Public Health Association	Washington DC
		<i>Adviser</i>		
5	Dr W A Kramer	Chief Information and Research	Office of International Health Relations	U S Public Health Service
		<i>Adviser</i>	Washington DC	
5	Mr J D Tomlinson	Assistant Chief	Division of International Organization Affairs	Department of State
		<i>Adviser</i>	Washington DC	

Venezuela

1	Dr A Arreaza Guzmán	Director of Public Health	Ministry of Health and Social Welfare	Caracas
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Venezuela (contd)

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Dr D Castillo Assistant to the Director of Public Health Ministry of Health and Social Welfare Caracas

Dr D Curiel Medical Chief Division of Epidemiology and Vital Statistics Ministry of Health and Social Welfare Caracas
Alternate

Dr S Ruesta Marca Technical Assessor Ministry of Health and Social Welfare Caracas *Adviser*

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Dr A Stampar President Yugoslav Academy of Sciences and Arts
Professor of Public Health and Social Medicine University of Zagreb

Dr D Juzbazić Professor, Medical School of Skoplje *Alternate*

Dr P Gregorić Minister Government of the People's Republic of Croatia President Public Health Protection Committee
Belgrade

TABLE II

MEMBERSHIP OF THE EXPERT COMMITTEES AND SUB COMMITTEES OF THE INTERIM COMMISSION EXPERT COMMITTEE FOR THE PREPARATION OF THE SIXTH DECADE REVISION OF THE INTERNATIONAL LISTS OF DISEASES AND CAUSES OF DEATH

- Dr. E. Backer Sc.D. Chief Demographic Section Central Bureau of Statistics Oslo Norway
- Dr. S. T. Bok Professor of Medicine University of Leiden Chief Section for Statistics Institute for Preventive Medicine Leiden Netherlands
- Dr. D. Curiel Medical Chief Division of Epidemiology and Vital Statistics Ministry of Health and Social Welfare Caracas Venezuela
- Dr. P. F. Denoix Chef des Services techniques de la Section du Cancer Institut National d'Hygiène Paris France
- Dr. Thurber Fales Sc.D. Research Associate School of Hygiene Johns Hopkins University Baltimore Md. United States of America
- Dr. M. Kacprzak Professor of Hygiene Director State School of Hygiene President, National Health Council Warsaw Poland
- Dr. Percy Stocks Chief Statistician (Medical) General Register Office London United Kingdom (*Chairman*)
- Dr. J. Wylhe Professor of Preventive Medicine Queen's University Kingston Ont., Canada
- Member from the USSR not yet appointed
- Secretaries* Dr. Maria Cakrtova member of the Secretariat of the Interim Commission
J. T. Marshall Assistant Dominion Statistician Acting Director Social Welfare Statistics Division Dominion Bureau of Statistics Ottawa Canada

INDEX SUB COMMITTEE

- S. D. Collins Sc.D. Head Statistician Division of Public Health Methods (U.S. Public Health Service) Bethesda Md. United States of America (*Chairman*)
- J. T. Marshall Assistant Dominion Statistician Acting Director Social Welfare Statistics Division Dominion Bureau of Statistics Ottawa Canada (*Secretary*)
- I. M. Moriama Ph.D. Chief Mortality Analysis Section National Office of Vital Statistics U.S. Public Health Service Washington, D.C. United States of America
- Winifred O'Brien R.N. Supervisor Nosology Section Vital Statistics Branch Dominion Bureau of Statistics Ottawa Canada
- Dr. A. H. T. Robb-Smith Nuffield Reader in Pathology University of Oxford United Kingdom

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- Dr M Ciuca Co-Director Cantacuzène Institute Professor of Bacteriology University of Bucharest, Roumania
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- Dr P F Russell International Health Division Rockefeller Foundation New York United States of America
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EXPERT COMMITTEE ON BIOLOGICAL STANDARDIZATION

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- Dr A A Miles Director Department of Biological Standards National Institute for Medical Research (Medical Research Council) London United Kingdom
- Dr J Orskov Director State Serum Institute, Copenhagen Denmark
- Major General Sir Sahib Singh Sokhey, Director Haffkine Institute Bombay India
- Dr W Aeg Timmerman Director Rijks Instituut voor de Volksgezondheid Utrecht Netherlands (*Chairman*)
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- Dr R Cruickshank Central Public Health Laboratory London United Kingdom

TABLE II

MEMBERSHIP OF THE EXPERT COMMITTEES AND SUB COMMITTEES OF THE INTERIM COMMISSION

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- Dr C Mani Deputy Director General of Health Services Government of India New
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- Dr Wasfy Omar Director Pan Arab Regional Health Bureau Alexandria Egypt
- Dr G H de Paula Souza Director Faculty of Hygiene and Public Health São Paulo
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- Dr G M Redshaw Chief Medical Officer Australia House London United Kingdom
- Ex officio members*

Président du Comité permanent de l'Office International d'Hygiène Publique

Dr M T Morgan Medical Officer of Health Port of London United Kingdom
(Chairman)

Director of the Pan American Sanitary Bureau represented at first session by

Dr A Macchiaravello US Public Health Service Consulting Epidemiologist
Pan American Sanitary Bureau Lima Peru

Representative of ICAO at first session

Dr J Duguet Médecin Chef du Centre d'Examen médical du Personnel navigant
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Rapporteur of the Joint OIHP/WHO Study groups

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Professor J J van Loghem Professor of Hygiene University of Amsterdam
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Dr Wasfy Omar Director Pan Arab Regional Health Bureau Alexandria
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- Dr M. Gaud Directeur de l'Office International d'Hygiène Publique
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CHRONICLE OF THE WORLD HEALTH ORGANIZATION

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Consider what knowledge is and you will see how inseparable it is from statistics. Medicine is no exact science, and diagnosis rests largely upon the law of probability which, in turn, is statistical. All scientific experiments are statistical arguments in favour of or in opposition to certain inductions and deductions. Further, statistics lend the authority that is necessary for their acceptance. The trouble in medicine does not lie with statistical method, but with the medical men who do not know how to use it.

DR LAWLASON BROWN

Towards Better Health Statistics

The Sixth Decennial Revision of the International Lists of Diseases and Causes of Death

If every member of the medical profession would come to agree with Dr Lawlason Brown ¹—a clinician not a statistician—and sound statistical methods would be applied to medical problems, the quantitative statements in scientific papers would become more trustworthy and new opportunities for progress would be within the reach of every research worker.

Unfortunately, medical statistics remains the unwanted child of the medical profession and progress in utilizing statistical methods has been achieved only slowly and at the cost of great pains.

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NEGOTIATIONS WITH
SPECIALIZED AGENCIES

COMMISSION
ON
NARCOTICS

COMMITTEE ON ARRANGEMENTS
FOR CONSULTATION
WITH NON GOVERNMENTAL
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¹ *Am. Rev. Tuberc.* 1920 /

Classification is fundamental to the quantitative study of any phenomenon. It is recognized as the basis of all scientific generalization and is therefore an essential element in statistical methodology. Uniform definitions and uniform systems of classification are prerequisites in the advancement of scientific knowledge. In the study of illness and causes of death, therefore, a standard classification of disease and injury for statistical purposes is essential.

Sixth Decennial Revision Conference an international success

The Sixth Decennial Revision Conference was described by some of those who followed the various stages of its work as a complete international success. Convened in Paris by the French Government from 26-30 April 1948, the Conference was opened by His Excellency M. Georges Bidault, French Minister of Foreign Affairs. Delegates from the following twenty-nine countries were present:¹

Belgium, Bulgaria, Canada, Chile, Cuba, Czechoslovakia, Denmark, Ecuador, Ethiopia, France, Greece, Guatemala, Hungary, Iceland, India, Ireland, Italy, Luxemburg, Mexico, Netherlands, Norway, Poland, Portugal, Siam, Sweden, Switzerland, United Kingdom, United States of America and Venezuela.

The organization of the conference was entrusted jointly to the competent French administration and to the Interim Commission of WHO, which had carried out the preparatory work under the terms of the Arrangement of 22 July 1946 concluded by the Governments represented at the International Health Conference.

The Sixth Decennial Revision Conference marked the beginning of a new era in international vital and health statistics. In addition to the adoption of a single comprehensive list of diseases, injuries and causes of death, it recommended the adoption of a far-reaching programme of international co-operation.

The main task of the conference was to review the statistical classification of diseases, injuries and causes of death, as it resulted from the two sessions of the Expert Committee of the Interim Commission of WHO.² This task was a heavy one, as the new classification was intended to be not only a list of causes of death, but also of causes of illness.

¹ For list of delegates see p. 132.

² See *Chronicle WHO* 1947, I, 83-16.

The old and the new classification

Such a list had necessarily to differ in content from the previous International Lists of Causes of Death. The work of research groups in the United Kingdom, the United States and Canada, as well as in other countries, showed clearly, however, that the general structure of previous International Lists was a useful framework around which a morbidity classification for statistical purposes could be evolved. Furthermore, the basic structure of these lists had withstood the test of well over half a century of use in numerous countries.

The very fact that no substantial changes were found necessary during that time suggests that it would be difficult to improve upon it.

The present classification, as resulting from the Revision Conference, represents an expansion of the previous International Lists to provide specific items (categories) for non fatal diseases and injuries. This process of expansion has been made so as to permit comparability with important titles of the fifth International List. It was not found essential, however, that there should be strict comparability for each individual subdivision. It must be remembered that, when one compares the frequency of a disease or cause of death now and twenty years ago, one is not really comparing the actual frequency of that particular disease, but the frequency with which a particular term is used to describe a disease state by observers differing in their education and medical outlook by a period of twenty years.

The framework of the new classification, which was approved by the Paris Conference, is given in the *Introduction and List of Categories*. Sections are provided for well defined infective and parasitic diseases, and for neoplastic, allergic, endocrine, metabolic and nutritional disorders. The remaining diseases are classified according to anatomical site, but special sections were provided for mental disorders, congenital malformations, certain diseases of early infancy, accidents and some ill defined conditions.

There are 800 categories in the Lists when the injuries are classified according to the nature of injury, or 763 when they are classified according to the external cause of injury. The content of each category is precisely defined by the *Tabular List of Inclusions*, which is a list of diagnostic terms assigned to each title of the classification.

In addition, an *Alphabetical Index* was prepared to assist in the coding of medical records and death certificates.

These three parts will constitute an International Manual, which will also contain rules for classification and three lists for tabulation of morbidity and mortality data. The lists are

- List A* Intermediate List of 150 Causes for Tabulation of morbidity and mortality. This List is being recommended for a minimum tabulation of mortality by age groups and other demographic characteristics for the country as a whole for large cities and for aggregates of urban and of rural populations.
- List B* Abbreviated List of 50 Causes for Tabulation of Mortality. This List is being recommended for a minimum tabulation of mortality for small administrative areas.
- List C* Special List of 50 Causes for Tabulation of morbidity for social security purposes.

What are the International Lists ?

There is some reason for believing that the general aim of the International Lists was not sufficiently well understood in the past. Indeed, criticism was expressed that the lists were not sufficiently up to date in the terminology used. It should be clear, however, that the Lists are not intended to be a scientific treatise but a working tool for classifying available data. They are not intended to take the place of any approved nomenclature indicating the most acceptable diagnostic terms to be used for the description of a morbid condition, but to serve for the compilation of data furnished by the doctors, some of which are often expressed in obsolete language. The Tabular List of Inclusions and the Alphabetical Index therefore contain, beside many approved diagnostic terms, also less desirable and obsolete terms, so as to allow assignment, even to an ill defined category, of any statement found on medical records and death certificates.

Furthermore, since the official nomenclatures of diseases in many countries—such as the Scandinavian and some countries of continental Europe—contain a large number of Latin and latinized names of diseases, it was thought necessary to include a limited number of Latin synonyms of such terms as cannot be easily recognized from English or French texts, and which are seldom used in medical records of other countries. These terms were included to enable workers of all countries to understand better the type of conditions included in the categories.

Multiple Causes of Death

If only one cause were responsible for the fatal result of an illness, the application of the classification would be relatively simple. Frequently, however, several morbid conditions are present at the time of death, whether complications or other associated conditions. As routine tabulations have to be limited to the presentation of only one cause, the problem arises as to which of the stated causes should be indicated in primary tabulations. A great many countries are at present using different methods for selecting the main cause to be tabulated.

The conference agreed on the underlying cause of death as the main cause and adopted an international form of medical certification so designed as to elicit the necessary information for uniform selection of the underlying cause.

Statistics and the medical profession

The suggested form of medical certificate places upon the certifying physician the responsibility of indicating the underlying cause of death—*i.e.*, the disease or injury which initiated the sequence of morbid events leading to death. Although this method has been already the practice in some countries, it is being recommended for the first time for international adoption. It is now up to each country to strive to secure a better understanding of medical certification in order to secure more accurate medical information. The successful application of the classification will ultimately depend upon the willingness of the attending physician to fill in correctly the certificates of death. There is sufficient evidence that members of the medical profession do not take a real interest in the quantitative aspects of their work. Satisfactory health statistics are difficult to obtain if the doctors are indifferent to, or inadequately trained in, the elementary aspects of statistics.

The WHO was therefore invited to survey the instruction given in the medical schools of various countries in health statistics, with special emphasis on the methods of collection and interpretation of statistical data, and to undertake any desirable action in this connexion.

Problems for the future

The new international lists resulting from the Sixth Revision represent an important step forward, as they offer for the first time an international classification for causes of both illness and death. In addition to these lists, the conference also recommended for international adoption other uniform procedures in the compilation and publication of statistics, such as the medical certificate of cause of death, rules for classification and lists for tabulation.

It is to be hoped that the international statistical classification which resulted from the work of the expert committee and of the Paris Revision Conference will be employed for the compilation of statistics of morbidity and mortality by all nations. If accepted by the World Health Assembly, the new classification will be used as the necessary basis for the classification of causes of illness and death from 1 January 1950.

Hard as the numerous authors of the new classification worked for several years they were unable to cope with all the problems with which they were confronted, and many of these are still subject to future action. Some of the most important of the still unsolved problems, such as the systematic study of multiple causes, and the statistical problems involved in foetal and infant mortality, including definition of stillbirth and immaturity, were brought by the conference to the attention of the World Health Assembly.

To study these problems, the conference recommended to the World Health Assembly the establishment of an expert committee on health statistics and the convening as occasion indicates, of international technical conferences. But perhaps the most interesting and far reaching proposal of the conference was that all governments should establish national committees on vital and health statistics, composed of representatives of national administrations entrusted with the compilation of such statistics. For those who are familiar with the difficulties of co-ordinating the various statistical services in a country in a problem of common interest, there is no need to emphasize the importance of such a recommendation.

The proposed committees are intended to study such special problems as the production of health statistics which are related to the family and the social economic structure, and those needed for tropical diseases or in areas facing population pressure or malnutrition. An advantage offered by such a decentralized system

would be the sharing of the burden among several groups which could specialize in certain problems and undertake detailed studies. A few of the problems suggested by the conference for study by the national committees of countries signifying interest are

- (a) the competent authorities of Belgium France Switzerland could study the question of completeness and accuracy of medical certification of causes of death in relation to the confidential character of the certificate
- (b) those of Canada and the United States of America could prepare an adaptation of the International Statistical Classification of Diseases Injuries and Causes of Death to the needs of armed services
- (c) the Canadian and United States national committees individually or jointly could pay particular attention to the methods by which health statistics might be linked with other types of related statistics in such a manner that they will be based upon a knowledge of the characteristics and distribution of the population
- (d) the vital statistics administration of Switzerland the United Kingdom and the United States of America could study methods of presentation of statistics of multiple causes of death
- (e) the competent authorities of Denmark France Norway Switzerland and the United Kingdom could pay particular attention to the problem of cancer registers and statistics
- (f) the competent authorities of the United Kingdom and of the United States of America could pay particular attention to the methods for obtaining reliable statistics on the frequency and causes of foetal death (classification of periods of gestation under 28 weeks classification of multiple causes methods of certification)
- (g) the competent authorities of France and India could pay particular attention to the problems of morbidity and mortality from tropical diseases
- (h) the competent authorities of Ecuador India Italy and Venezuela could study the problems involved in the statistics of malaria morbidity

It is recommended that the national committees, if set up, would report their findings from time to time to the expert committee of WHO for international consideration, clearance of national viewpoints and co ordination with the interested statistical services of inter governmental organizations

Third session of the Expert Committee on the Sixth Decennial Revision of the International Lists of Diseases and Causes of Death

Before being submitted to the World Health Assembly for final approval and adoption, the classification was reviewed again by the expert committee in the light of the discussions at the Paris Conference

The committee, which met in Geneva from 4-7 May, was not bound by any limitations, but was given a free hand to establish the final terms of the classification and of other related documents. This was a high mark of approbation. Indeed, it is difficult to quote similar examples of Government representatives in an international Conference showing such confidence in a small body of experts

In a few weeks the World Health Assembly will be in a position to adopt WHO regulations for the widespread application of the new International Lists. The expert committee on the sixth decennial revision will thus be the first of the technical groups set up by the Interim Commission to conclude its work. Its task will have been completed even before the interim period of the organization has drawn to a close. Its achievement, it may be said, will stand as a model of international co-operation for other similar groups

Biological Standardization

Second Session of the Expert Committee Geneva 18-23 March

Although the second session of the Expert Committee on Biological Standardization¹ concluded without any final decision on the standardization of biological products other than those for which international standards already existed it considered carefully two

¹ The following attended the meeting

Professor E. Grasset, Directeur de l'Institut d'Hygiène, Geneva, Switzerland

Dr A. A. Miles, Director, Department of Biological Standards, National Institute for Medical Research (Medical Research Council), London, United Kingdom

Dr J. Ørskov, Director, State Serum Institute, Copenhagen, Denmark

Major General Sir Sahib Singh Sokhey, Director, Haffkine Institute, Bombay, India

Dr W. Aeg. Tunmerman, Director, Ryks Instituut voor de Volksgezondheid, Utrecht, Netherlands (Chairman)

Professor J. Tréhouart, Directeur de l'Institut Pasteur, Paris, France

[Continued on following page]

subjects of outstanding topical importance—the standardization of BCG and of cholera vaccines

The standardization of BCG vaccine had been considered at the first session¹, but the present session provided the first opportunity for a full discussion by French and Danish workers on the differences which are known to exist in the production and application of the vaccine in Paris and Copenhagen. Although it is too early to judge the results of this exchange of views, it is hoped that the discussion will considerably assist the establishment of a standard BCG vaccine, which is desirable in view of the several antituberculosis campaigns either projected or already in operation.

Cholera vaccine

The urgency of the need for standardizing cholera vaccine became obvious during the recent cholera epidemic in Egypt, when the numerous vaccines received from various countries appeared to differ appreciably in concentration. This made it necessary for the Egyptian health authorities to adopt various methods of application and thus accept both a further complication of their already heavy task and a risk of errors being committed by the vaccinators.

The committee was confronted with a difficult task: the variability in the dimensions of the vibrios, and autolytic changes in the culture, placed difficulties in the way of standardizing the bacterial content of the vaccines by counting the microorganisms or measuring the turbidity of their suspension.

It is well known that the various strains of vibrios exhibit considerable differences in their morphology as well as in their behaviour. Yet most of the vaccines now produced include at least two of the Ogawa, Inaba and Intermediate forms of the vibrio, and it

Dr M V Veldee Chief Biologics Control Laboratory National Institute of Health (U S Public Health Service) Bethesda Md United States of America

Secretary Dr R Gautier Counsellor of the Interim Commission

The following were also present as expert advisers

Dr A Bonnefoi Chef du Service des Vaccins de l'Institut Pasteur Paris France

Dr P Bruce White National Institute for Medical Research (Medical Research Council) United Kingdom

Dr J Bretey Institut Pasteur Paris France

Dr J Holm Tuberculosis Division State Serum Institute Copenhagen Denmark Chairman of the WHO Expert Committee on Tuberculosis

¹ *Chronicle WHO* 1947 1 109

is not impossible that the various mixtures of strains result in some differences in the immunizing power of the vaccine

This is one of the reasons why the wisdom of ensuring all eventualities by universal issue of mixed vaccine was questioned. In a paper submitted by Dr Bruce White from the National Institute for Medical Research, London, the attention of the committee was drawn to the fact that it would seem rational in combating an epidemic of single and fixed serological type and where the inter-currence of the other form or forms of cholera infection is improbable to employ a monovalent vaccine in the hope of achieving the maximum effective response. In the opinion of Dr Bruce White, the recent Egyptian epidemic due solely to the Inaba type furnishes a case in point. In examining samples of sera from some 40 vaccinated persons—samples supplied to him by the Egyptian public health authorities without information as to the vaccines concerned or the dates of inoculation—he found indications that in the majority of cases the O antibody response, mostly of a low order (1:10—1:50) was predominantly against the Ogawa type. His conclusion was that, if the sera examined were in any way representative of those of the inoculated population as a whole, the persons inoculated were better protected against the Ogawa than the epidemic Inaba form. More study will be necessary before it is clear which of the two types of vaccine mixed or unmixed, is apt to yield more satisfactory results which means in effect that the standardization of the cholera vaccine will have to await the results of these studies.

The discussions of the committee left no doubt, however, that the choice of a vaccine, while remaining an outstanding problem, was not the only one for solution. It is not yet clear what form of animal test, if any, can furnish a valid index of protective value against cholera in man. In view of these difficulties, the committee agreed to defer setting up an international standard for cholera vaccine until it had further information on the relation of immunizing potency in laboratory animals to that in man. To this end the committee expressed the hope that all facilities will be provided by the Health Authorities of India to Major General Sir Sahib Singh Sokhey for controlled tests in man of the protective action of cholera vaccines of high immunizing potency in animals and containing all necessary smooth antigens.

In the meantime, the committee recommended the establishment of two reference preparations of cholera vaccine of the Ogawa and

Inaba strains respectively Dr Veldee undertook to prepare batches of freeze dried vaccine of proved immunizing potency in mice for these two types. These preparations will be tested by interested laboratories for their suitability as reference preparations which when established, will be held and distributed by the State Serum Institute, Copenhagen.

To facilitate the use of the two reference preparations in comparative tests of potency, Sir Sahib Singh Sokhey agreed to prepare freeze dried living cultures of virulent Ogawa and Inaba strains which will be held by the Kasauli Institute for distribution on request to national control centres.

In response to a request made by Dr Shousha Pasha during the fifth session of the Interim Commission for a diagnostic anticholera agglutinating serum, the committee decided that laboratory workers throughout the world would be better served by the establishment of a reference preparation of cholera O antigen, suitable for the immunization of rabbits, to produce antisera capable of distinguishing the true cholera and the El Tor strains from all other cholera like vibrios. Dr Bruce White agreed to prepare this material. Nevertheless, to facilitate the identification of Ogawa and Inaba strains within the groups of cholera vibrios the committee recommended the establishment of reference preparations of Inaba and Ogawa monospecific agglutinating antisera, to be prepared in India and held for distribution by the State Serum Institute (Copenhagen).

Other vaccines

The committee reviewed the possibility of establishing international standards for several vaccines, sera toxins, antitoxins and toxoids. It was agreed that an attempt to standardize the pertussis vaccine and antipertussis sera was premature.

A number of streptococcus antitoxins of high neutralizing and flocculating potency will be examined in various laboratories for their suitability as a provisional international standard. Should an international standard be established, it would, in the opinion of the committee, be desirable to equate the potency of the proposed standard with the standard of the U. S. National Institute of Health standard.

Steps had been taken already at the first session of the committee for the establishment of an international standard for tetanus

toxoid ¹ To facilitate the provision for interested laboratory workers of samples of anomalous toxins and antitoxins, Dr Trufonel agreed to undertake to receive and distribute such samples. The committee considered the extensive use made both of international and US National Institute of Health units in designating the potency of tetanus antitoxin, and reviewed the circumstances in which the international unit was defined in 1928. It recommended that, if informed opinion in interested countries were in favour of the step, the international unit for tetanus antitoxin should be redefined so as to equal the unit of the US National Institute of Health.

A Model Tuberculosis Control Scheme in Poland

Tuberculosis annually takes toll of 50,000 lives in Poland, and 500,000 of the country's inhabitants are at present suffering from the disease in an active form.

Devastated as it was by the war, and still requiring the utmost efforts of all its people for the fundamental tasks of reconstruction, Poland has not the funds, material or personnel which a full scale campaign against tuberculosis would demand.

These paramount factors—the extent of the problem and the lack of means to cope with it effectively—were governing considerations in studies undertaken by the Interim Commission in the autumn of 1947, in response to a request from the Polish Government for advice on its tuberculosis programme. A plan was conceived for the establishment in one of the provincial centres, by the co-operation of all interested Polish and foreign agencies, of a model tuberculosis control scheme with adequate dispensary and laboratory facilities.

Dr W. Gellner, one of the Secretariat's tuberculosis specialists, went to Poland at once, to place the proposal before the authorities in detail and advise on putting it into effect.

The object of the model scheme is to furnish the means for gaining experience in the application of methods of fighting tuberculosis which have been practised in many countries with great success. With such modifications as may be required by specific economic and social conditions, the scheme will develop the most suitable methods and procedures and will thus be able to serve as an example and training centre for the whole country.

¹ *Chronicle WHO* 1947 1 107

Several considerations suggested the choice of the City and Province of Lodz for the location of the centre. The city and province form a unit having some 2,400,000 inhabitants, of whom two fifths live in industrial and the remainder in rural areas—a division of population proportionate to that of the country as a whole and on a large enough scale for the purposes of the scheme. The workers of the city area are organized in trade unions affiliated to a federation of trade unions whose co operation it was hoped to enlist in the work of tuberculosis control. Furthermore, Lodz is a university city with a long tradition in tuberculosis work which will benefit the work in the province.

It was recognized, as the first principle of organization, that the campaign would need the co operation of the State, of social insurance organizations, of those voluntary organizations, such as the Polish Red Cross and Caritas, whose programmes permit, and of other public bodies—workers' unions, peasants' organizations, Women's League, etc. A close collaboration of the Ministries of Industry, Labour and Social Welfare, and Health, and of all other State departments concerned, was essential.

To put this principle into effect on the limited scale of the area selected for the scheme, a meeting was held on 18 October 1917 in the offices of the Provincial Government. It was attended by representatives of the State, the City of Lodz, the Social Insurance Institute, the Army, the Polish Red Cross, Caritas, and other bodies. The agencies and institutions represented affirmed their resolve to co operate in the model control scheme, and constituted a provisional Joint Tuberculosis Committee, the establishment of which was subsequently confirmed by the Government.

The function of the committee will be to administer in the province of Lodz a programme of tuberculosis control previously approved by the responsible government departments. Provision was made for the creation of three sub committees—one for propaganda and health education, the others for medical organization and social assistance respectively—and it was agreed that the committee should establish an office headed by a director.

The second principle of organization was to ensure for villagers the same possibilities of diagnosis, treatment, and after care as would be at the disposal of city dwellers. This entailed the establishment in the main towns of the counties (powiats) of properly equipped and staffed tuberculosis dispensaries, to which all suspect

cases would be referred for definite diagnosis from dispensaries lacking the necessary equipment

The third principle was the notification of all discovered cases of tuberculosis to a central office to be established in connexion with the Joint Tuberculosis Committee to register such cases and to record their clinical condition and movements

The scheme will embody the following basic features

Intensive health propaganda It is proposed to utilize every possible channel of approach to the public—Church, radio, film, Press, school, organized labour Without causing unnecessary alarm, this propaganda will lay special stress on the danger of infection and how to avoid it, the value of mass examinations and prophylaxis the importance of individual examinations when certain symptoms become apparent, and the good chances of a cure for cases discovered at an early stage of the disease But it will at the same time educate the individual citizen to a sense of his responsibility for help in the solution of the problem

Prophylaxis by BCG vaccination It is now generally accepted that BCG vaccination produces a certain degree of immunity, and in a country like Poland, where the sources of infection are so numerous large scale vaccination is definitely indicated Valuable work in this direction has been done by the Danish Red Cross in different parts of the country The model control scheme proposes to concentrate the work in the Lodz area, and to supplement it with tuberculin testing

Case finding by mass radiography Large selected groups of the population such as the workers of certain industries and trades, and perhaps the entire populations of some villages, and of towns of both small and larger size will be examined

Improvement and unification of the methods of diagnosis The aim is to put at the disposal of every suspect tuberculous person the possibility of a complete investigation including radiography and sputum test in order to make possible an adequate classification of the cases and to establish a rational system of disposition of the patients according to their classification

Institutional treatment The number of beds available for treatment of patients in the country is grossly insufficient, and for this

reason the government's announcement that the number of institutional beds for tuberculosis would be increased in 1948 by several thousands was greeted with great satisfaction. The Joint Tuberculosis Committee will have to explore all means of increasing the number of beds at their disposal.

Measures of diversional and occupational therapy are also planned to counteract the tedium of institutional life and provide a link with the outside world.

The study and application of the latest methods of chest surgery and chemotherapy The newly established municipal hospital sanatorium at Chojna (Lodz) will serve as the centre for this work.

Rehabilitation of the patient A series of practical measures will aim at enabling the clinically cured and the chronic tuberculous patient to take part again in the social and economic life of the community.

Social assistance It is hoped to establish facilities for social assistance to support the patient and his dependant during the period of his illness. This part of the plan is probably the most difficult. The non existence of such facilities at present militates against the effectiveness of all other control measures.

Dr Gellner remained in Poland two months (September-December 1947), and later returned for a further month (February-March 1948). During his visits he had numerous discussions with Ministers and their assistants and with the representatives of organizations, and received assurances of co-operation on all sides.

The Ministry of Industry and Commerce promised help for three special projects: the establishment of a tuberculosis sanatorium for textile workers of the Lodz district and of a night sanatorium for such patients as are in a condition to work, and an investigation by mass radiography into the incidence of tuberculosis in the Lodz textile industry. The same Ministry undertook to finance from the "UNRPA Zloty Fund" an administrative office of the Joint Tuberculosis Committee, and this office has been established since 1 January 1948.

The Lodz Federation of Trade Unions agreed to support the scheme out of their own funds and to organize collections within their affiliated trade unions for the same purpose.

Other Polish agencies giving co operation include the Peasants' Self Help Organization in Lodz, the Polish Red Cross Society, the Women's League and Caritas

Foreign organizations which have given practical co operation include the British Council, the National Association for the Prevention of Tuberculosis (London), the National Tuberculosis Association (New York), the Belgian Œuvre Nationale, the League of Red Cross Societies (Geneva), the Don Suisse, the World Students' Relief Society, the Anglo American Quaker Relief Mission, the Baptists' Relief Committee for Poland, the American War Relief Services, the Polish American War Relief, the Swedish Relief Services, and the Danish Red Cross

WHO PUBLICATIONS

Epidemiological and Vital Statistics Report

Vol I, No 9, February 1948

Decline in Infant mortality Rate

In nearly all countries where adequate information is available the infant mortality rate is now as low as or often lower than it has ever been. This is the conclusion reached by Mr Knud Stowman, Epidemiological Consultant to the Interim Commission, in an article on infant mortality published in the *Epidemiological and Vital Statistics Report 1948 Vol I No 9* (February). The reasons for this, the author suggests, are to be found in the highly developed technique for the protection of infant life and in the effective help rendered to war-ravaged countries by international action.

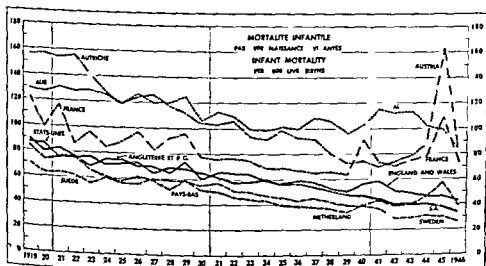
The steady reduction in infant mortality began little more than fifty years ago in most countries even more recently. In 1876-1880 all of Europe with the exception of the British Isles and the Scandinavian countries had infant mortality rates exceeding 150 per 1 000 live births. In Austria, Hungary, southern Germany and Russia the rates were 250 or more per 1 000. In 1912 when rates were below 100 per 1 000 in England and Wales, Ireland, the Netherlands, Scandinavia and Switzerland, they were still above 180 in Austria, Hungary, Roumania and Russia. But by 1932 only Hungary and Roumania recorded such high rates, and so far as is known they had disappeared from Europe by 1946. Of all the countries which published statistics, only four reported rates of 160 or more, and none above 185 per 1 000 live births.

Immediately before the Second World War, infant mortality rates of less than 50 per 1 000 were reported in Australia, Iceland, the Netherlands, New Zealand, Norway, Sweden and Switzerland. To these countries must now be added Canada, Denmark, the United Kingdom, the United States and the white population of the Union of South Africa. In Australia, New Zealand and Sweden, the infant mortality rate is even below 30 per 1 000. Rates varying between 56 and 85 per 1 000, which would have been considered highly satisfactory in almost any country twenty years ago, were recorded in 1946 in Austria, Belgium, Finland, France, Ireland, Italy and Spain. These groups together cover nearly all of northern, western and southern Europe, as well as the temperate zones of America and Oceania.

Infant mortality rates from 100 to 130 prevailed in 1946 in Bulgaria, Czechoslovakia, Germany, Hungary, Malta and Portugal, as well as in Mexico, Venezuela and certain Central American states. Before the Second World War, rates of about 140 were reported in Poland and Yugoslavia, but more recent information has not been received from these countries. Rates from 160 to 180 were reported in 1946 in Chile, Egypt, India and Roumania.

The figures summarize the present situation in the countries which reported infant mortality data to the Interim Commission or to the United Nations Statistical Office. It will be seen that very high rates are now the exception and that there is a tendency to a natural grouping reflecting the general trends of economic and social conditions.

Infant mortality rates for the years following the Second World War are interesting in that they bear no relation to the increase in the birth rate. The striking increase in the birth rate characteristic of the last two years has not resulted in a corresponding increase in infant mortality. With a birth rate of 30 per 1 000 inhabitants and an infant mortality rate of 39 per 1 000 live births the Netherlands has proved that security of infant life is not incompatible with a vigorous fertility.



It must be pointed out however that no information has been received from Far Eastern countries and from the greater part of Africa—both areas where conditions are far from satisfactory.

So far figures for only the total infant mortality are available for the years following the Second World War. A more valuable and informative analysis may be made when data regarding the age distribution of infant deaths become available. The reduction of neonatal mortality depends mainly on prenatal care and on good obstetrics. It goes hand in hand with the reduction of maternal mortality. The reduction of mortality in infants aged over one month depends largely on correct feeding and control of environmental factors. It follows the establishment of health centres and the improvements of general public health work.

Summarizing the reports received Mr Stowman points out that despite the progress achieved there are still considerable differences from one country to another in the chances of survival of the newborn. In the more favoured countries they have a 97% chance to reach the age of one year but in others less favoured only an 80% chance. However even in these latter countries their chances are constantly increasing.

REPORTS FROM WHO FELLOWS

Many of the letters and reports received from WHO Fellows have been of such interest that they deserve to be read by a wider public. They demonstrate more vividly than a series of facts and figures both the character of the fellowship programme and the response of the Fellows themselves. Selections from these reports will therefore be published from time to time, but it must be emphasized that the opinions expressed are those of the Fellows.

* * *

Public Health Administration in the United States

Dr Vladislav Kaplan is a district health officer in the city of Prague Czechoslovakia. He has recently spent six months on a study tour as a WHO Fellow studying public health administration with special reference to maternal and child welfare and school hygiene in the United Kingdom and the United States.

During my tour I visited schools in Baltimore Boston Chicago New York City New York State Philadelphia Rochester and Washington. I used every opportunity to discuss the different aspects of school health organization with the officials of the services in departments of health or education as well as with school doctors and school principals. The types of services naturally vary widely. In some places as in Chicago for example only the control of communicable diseases is organized. In other places as in New York complete examination of all children is made every year. One of the best organized services was that in Philadelphia.

The Commonwealth of Pennsylvania on 1 June 1945 passed a new school health act requiring a complete medical and dental examination of children of school age and of teachers and other school employees in all elementary and secondary schools within the State. This complete examination is made as a routine measure once every two years. Additional examinations are made on the recommendation of the teacher or the nurse. Not more than four complete medical examinations may be made in one hour and each doctor must be assisted in the examination by a registered nurse. Parents of the children are urged to be present at the examination and the opportunity is used for health education. Great emphasis is placed on the follow up of the correction of all discovered defects and this task is left principally to the school nurses.

In general the new trends in school health services are less frequent but more complete examinations of school children better follow up and

correction of discovered defects better services for crippled children closer co-operation with teachers doctors nurses and parents and improvement of health education

The protection of the mother and child forms one of the most effective parts of the public health programme in the United States. The results so far achieved in reducing the infant mortality rate in the past forty years have been most encouraging and have resulted in a decrease from 161 per 1 000 live births in 1900 to 39 in 1944

The Children's Bureau in Washington co-ordinates the general programme and provides information and advice to the state services. I visited many maternity hospitals nurseries for the new born and special nurseries for the premature born. In addition I visited many welfare clinics and clinics for expectant mothers and discussed with their staff local regulations and the recent developments in these services.

The Rochester Child Health Project is one of the most complete programmes for maternal and child health in the United States. The prenatal clinic is interested not only in the health and the diet of the expectant mother but in her mental attitude towards the coming baby. After the birth of the baby every effort is made to give the mother and infant not only adequate physical care but also to encourage the mother to have the correct mental approach towards the child. When the mother returns home the public health nurse helps her with the care of the child and encourages her to take it regularly to the welfare clinics. In the case of normal development the mother visits the clinic every month during the child's first year of life every second month during the second year and then every sixth month until the child comes of school age. At the welfare clinic the child is examined for general health supervision satisfactory feeding and for immunization against certain communicable diseases. Emphasis is placed on teaching the parents about the social development and habit formation of their children. The education of parents is continued in pre school clinics but nursery schools are used as demonstration centres for all mothers. This programme in Rochester covers all children from their infancy to the conclusion of their period at high-school.

The public health nurse is one of the most successful members of the public health services in the United States. I was extremely interested in following their educational curriculum and their work in the field especially in relation to health education in families.

When I compared the organization of public health services in the United States with that existing in my own country I found in each case that the health services in the United States were more highly developed and consequently were more successful. When I considered the matter further I found that the structure of the Czechoslovak public health organization is often very sound but the interpretation and the use of health regulations throughout the general public rather poor. In other words I feel that it is health education which has made the public health organization in the United States so successful.

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Biological Standardization

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The Department of National Health and Welfare of Canada and the Department of Biological Standards of the National Institute for Medical Research London intend jointly to adopt a Canadian British standard for oxophenarsine hydrochloride. The committee was informed of the plans but did not consider that international action would be justified at this stage. An offer made by the two countries to place their standard at the disposal of the committee as a reference preparation for oxophenarsine was accepted

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The committee considered that there was at present no need for an international standard or reference preparation for Dimercaptopropanol (BAL)

Ceylon and Monaco apply for membership

The Dominion of Ceylon and the Principality of Monaco have applied for membership in the World Health Organization

These requests will be submitted to the World Health Assembly which met for the first time in Geneva on 24 June

Membership in the World Health Organization is open to all States provided their application is approved by a simple majority vote of the World Health Assembly

Special postal cancellation during World Health Assembly

The Swiss Post Office has made arrangements for a special cancellation to be used on all mail posted at the United Nations Branch Post Office in the Palais des Nations for the duration of the First World Health Assembly

Mail sent out from that branch will be marked *Genere 1^{re} Assemblée mondiale de la Santé* together with the date of posting. Since this will be the only post office in Switzerland using the special cancellation the total number of cancellations of this kind will be relatively small thus increasing their philatelic value.

Ratifications

Afghanistan Belgium Brazil Bulgaria Denmark France Hungary Iceland Pakistan Poland Roumania the United States of America have ratified the Constitution of WHO. This brings to 49 the number of full members of the new organization. In addition Burma the Philippines Republic Paraguay and Venezuela have also ratified the Constitution but without having deposited as yet the instruments of ratification.

WHO Representation

During the period between 16 April and 1 June the Interim Commission was represented by observers who attended or took part in the meetings of the following organizations:

Second Special Session of the United Nations General Assembly Lake Success 16 April

Conference on Safety of Life at Sea London 23 April

General Conference on Specialists PCIRO Gwatt Switzerland 26-30 April

Drafting Committee of the Commission on Human Rights Lake Success 3 May

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Dr M Pasqua Member of the Secretariat of the Interim Commission

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W Thurber Fales (Vice Chairman)

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CHRONICLE OF THE WORLD HEALTH ORGANIZATION

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there is reason to hope that it may be possible to put an end for ever to all exaggerated and extravagant quarantine measures which are still to be found in certain countries, and which wreck commerce and navigation, and yet fail to provide for public health any safeguards proportionate to the damage caused'

A PROUST, 1896

The International Control of Cholera, Smallpox and Plague

A Note on the First Session of the Expert Committee on
International Epidemic Control and the Three Joint OIHP WHO
Study Groups on the Pestilential Diseases

On 30 September 1848, the *Matteo Bruzzo* sailed from Genoa carrying two hundred passengers. Several cases of cholera were discovered on board during the voyage, and after unsuccessful attempts to enter a port, the ship was taken for quarantine purposes near the island of Pinosa in Italy. The passengers of the ship were finally permitted to land on 27 January 1849 at Leghorn (Livorno). Their journey from Genoa to Leghorn had lasted four months!

This and many similar incidents vividly demonstrate the problems which have confronted health authorities ever since quarantine regulations were adopted as defensive measures against the epidemics which repeatedly afflicted European populations.

There are only two ways of ensuring active defence against pestilential diseases: to eradicate the endemic foci or to maintain

a permanent control on everything coming out of, or passing through, the endemic or the temporarily contaminated areas

The eradication alone of the endemic foci would relieve, once and for ever large parts of the world from the constant danger of being stricken with cholera, smallpox or plague. But many years will elapse before this long cherished dream of epidemiologists comes true. The suppression of the pestilential diseases is hardly imaginable without the existence throughout the world—including the remote endemic areas in Asia and Africa—of satisfactory sanitation, and without the complete suppression of such important vectors as are known to be transmitters of plague, yellow fever and exanthematic typhus. Until this is done, the public health officer will have to rely largely on the quarantine measures which offer some security at the cost of much complication in international communications.

Are there any reasonable prospects of simplifying the international quarantine system without increasing the ever present danger of new epidemic outbreaks?

The Interim Commission examined this problem, and it was agreed that the mechanism of sanitary conventions now in force is no longer adequate. The present system was recognized to be too slow and unwieldy for effective control of the international spread of disease owing to the necessity of subjecting any new conventions to complex and protracted national legislative processes.¹ It was, therefore, proposed that the old conventions should be replaced by international health regulations which should be formulated by the new organization. Once the regulations are adopted by the World Health Assembly, they shall come into force for all Members after due notice has been given of their adoption, except for such Members as may notify the Director General of rejection or reservations within the period of time stated in the notice.²

An Expert Committee on International Epidemic Control was appointed to examine the circumstances underlying the spread of the major epidemic diseases and to restate the principles which should serve as a basis for their international control.³

¹ It will be recalled that the Convention signed on 17 January 1901 did not become effective until 17 October 1910.

² Article 2 of the WHO Constitution.

³ In the terms of reference of the expert committee *Off Rec WHO* 6 179.

The first session of the committee was preceded by the meeting in Paris of three study groups which were set up jointly by the Office International d'Hygiène Publique and WHO to furnish expert advice on the pestilential diseases to the expert committee. The study groups made observations on recently established facts which in the opinion of their members, should be taken into consideration in the drafting of the new international sanitary regulations, and undertook or recommended investigation on points which still require elucidation. One study group dealt with cholera and met from 5 to 7 April, another considered smallpox and met from 8 to 10 April, the third, which dealt with plague typhus and some other diseases, met from 31 March to 3 April.

(cholera)

If, generally speaking, the measures of defence against cholera can be said to have yielded satisfactory results, they do not appear to be entirely without fault. While large parts of the world are effectively protected, little has been done to attack the endemic foci which remain a permanent menace to the security of all. Another defect of the present system is that it inevitably results in abuses which sometimes interfere to an intolerable extent with the freedom of travelling of people coming from, or passing through, countries suspected of being cholera infected. As was pointed out recently in one of the WHO periodicals, the cool and competent advice of the experts who had drafted rules of protection against cholera embodied in the international sanitary conventions was set aside, and health administrations in a number of countries swayed by emotional pressure from an ill informed public applied quarantine and other measures of self protection at variance not only with their legal international obligations, but with modern medical science.⁴

Better Quarantine

What is medical examination? This question was often asked in relation to the quarantine measures against cholera, but the answer given was not always similar. The International Sanitary Convention, 1926, is amended by the International Sanitary Con-

⁴ BIRAUD A. and KALI P. M. *Epidem. Vital. Statist. Rep.* (1948) 1: 141

vention, 1944, provides that the crew and passengers of cholera suspected ships may be subjected to surveillance (Article 31)

The term surveillance is defined to mean that persons are not isolated but that they may be subjected in the places of arrival to a medical examination. But experience has shown that the term medical examination, as commonly used, was not sufficiently well defined, and it has remained a source of dispute. The study group therefore suggested that "medical examination" as mentioned in the international sanitary conventions must be understood to include such laboratory examinations as are deemed necessary by health authorities (including rectal swabbing). This should be stated explicitly in the definitions to be given in the new international sanitary regulations now in course of preparation.

In view of the relative character of the immunity conferred by vaccination, it was thought that vaccinated persons should not be exempted from all measures of control by the international quarantine regulations.

Vaccination

Cholera vaccine was recognized to be of definite value in the prophylaxis of the disease provided that it was prepared with vibrio strains of real antigenic potency. The immunity—which is known to be relative—is manifest as early as the fourth day after injection and reaches its full effectiveness on the eighth day, to last at least six months. A single injection of 1 ml. of vaccine confers an appreciable immunity and constitutes a proper procedure for mass vaccination campaigns. Two injections at a week's interval are, however, preferable and should be given to individuals particularly exposed to contamination (sanitary, police, military and administrative personnel). There is no contra-indication to cholera vaccination, as it gives little or no reaction, it can be applied to all ages provided care is taken in the case of infants to reduce the dose in proportion to body weight.

Most of the vaccines now produced include at least two of the Ogawa, Inaba and Intermediate types of the vibrio. It will be recalled that the wisdom of utilizing a mixed vaccine has been questioned and that this problem was already studied by the Expert

Committee on Biological Standardization⁵ New substance for discussion was provided by the study group, which confirmed that the Ogawa and Inaba types of cholera vibrio may be responsible for successive epidemics of equal severity in a particular area and that they do not have a fixed geographical distribution. These types do not appear to represent all true sub species, as under laboratory conditions the Ogawa type may be transformed to the Inaba type, even though the reverse has not been observed.

An important point brought out by the discussions of the study group, was that at the end of the disease and during convalescence an increasing proportion of the vibrios excreted by the patient are of the rough variety. Transformation from the smooth to the "rough" form corresponds to a loss of pathogenicity of the organism. No reversion from the rough to the smooth form has, so far, been observed. Some of these facts will have to be carefully weighed by the Expert Committee on Biological Standardization when a final decision is arrived at with regard to the definition of a universally acceptable anti cholera vaccine.

Smallpox

The general discussion held by the study group on the changes which may be necessary to secure effective defence against smallpox was preceded by a review of recent developments in knowledge regarding the pathogenic agent and its mode of transmission.

Pathogenic Agent

The mere demonstration of the presence of Paschen bodies could not be regarded, it was agreed, as a practical method of differential diagnosis. It was safer to rely on the characteristic fever which always precedes the eruption in smallpox and drops at the moment of its appearance, but which, in chickenpox, accompanies every bout of eruption. The research carried out by Burnet at the Walter and Eliza Hall Institute of Pathology and Medicine, Melbourne, on the agglutination of chicken cells with vaccine virus for the evaluation of antibodies and the degree of immunity was thought to be potentially valuable, and it was felt that the experiment should be repeated.

⁵ *Chronicle WHO* 2, 11.

vention, 1944, provides that the crew and passengers of cholera suspected ships may be subjected to surveillance (Article 31)

The term surveillance is defined to mean that persons are not isolated but that they may be subjected in the places of arrival to a medical examination. But experience has shown that the term medical examination, as commonly used, was not sufficiently well defined and it has remained a source of dispute. The study group therefore suggested that medical examination as mentioned in the international sanitary conventions must be understood to include such laboratory examinations as are deemed necessary by health authorities (including rectal swabbing). This should be stated explicitly in the definitions to be given in the new international sanitary regulations now in course of preparation.

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preferred. As to the site, it was considered that, in infants, the arm remained the most satisfactory site. Hypodermic vaccination was considered a dangerous procedure.

Accidents which have occurred in vaccination from time to time, mostly in the form of grave or even fatal post vaccinal encephalitis, have been used by a minority as a justification for hastily condemning smallpox vaccination. The study group was firmly of the opinion that the danger of post vaccinal encephalitis for a community is not to be compared with that of smallpox in the absence of vaccination. The best way to avoid this complication was to carry out primary vaccination well before school age. New born babies should be vaccinated between the third and sixth months. In the case of an epidemic, all children, irrespective of age, should be vaccinated. Finally, in view of the gravity of 'generalized vaccinia' in infants suffering from eczema, such persons should be isolated from the other persons in their environment during the development of the vaccinal lesions.

The following definitions of reactions observed after revaccination were suggested for universal adoption.

Success: Characterized by a lesion identical to that of primary vaccination in its morphological characteristics as well as in terms of the duration of its development, in other words, the lesion goes through the stages of macule, papule, vesicle, pustule and scab, and develops within the fourteen days after vaccination.

Accelerated reaction (i.e. *modified*, or *vaccinoid* reaction). A vaccinal lesion which, after a maculo papular stage, shows a vesicle between the third and eighth days and may end in the formation of a scab. The two characteristics by which such a lesion can be identified are first, the formation of a vesicle, and, second, its development, which is definitely more rapid than in the case of a reaction to primary vaccination.

Precocious non vesicular reaction (so called immunity reaction). Characterized by the appearance, after the first day, of a vaccinal lesion which does not develop beyond the papulo macular stage, is pruriginous, and disappears at the latest on the third day.

Various tests carried out show that this is not a reaction of susceptibility to animal proteins which serve as a base for this vaccine virus. It might be well to abandon the term immunity reaction,

More study appeared to be necessary on the agent responsible for the various clinical forms which the disease is known to assume. Available evidence seemed to confirm the identity of the virus in the mild and malignant forms, but the scientific data to this effect were not entirely convincing. It was therefore recommended that new studies be undertaken by means of cultures on egg media.

Contagion and Transmission

It has long been known that the transmission of smallpox commonly occurred during the various stages of the eruptive period, particularly those of vesiculation and decrustation, the virus being transmitted either by direct or by indirect contagion. The preventive measures at present in force are based on the assumption that this was the usual mechanism for transmission, but the opinion has been expressed that present knowledge on this matter does not exhaust all possibilities. The study group, recognizing this, concentrated on the hypothesis—which was not yet proved, but which was recognized to be likely—that the enanthematous elements also helped to disseminate the virus through Pfluegge's droplets. It was recommended that the existence in bucco-pharyngeal secretions of the virus at the time of the enanthema and even during the various phases of the disease should be ascertained by means of cultures on chorio-allantoic membrane.

The duration of the incubation period has been variously described as ranging from eight to fifteen days. The study group considered that the duration was usually twelve days and that the adoption for quarantine purposes of a fourteen-day period as in previous conventions would provide an adequate margin of security.

Vaccination

Vaccination still remains the outstanding measure of defence against the disease. The study group recognized the superiority of calf lymph over vaccines grown *in vitro* or on chorio-allantoic membranes, it being recognized that in certain countries it is sometimes necessary to resort to passages in other animals to strengthen the activity of the virus. As regards the technique of vaccination, the multiple pressure method recommended by Leake* in 1927 was

* Cf. Memorandum on Vaccination against Smallpox. Memo 312/MED. Ministry of Health, London, 1948.

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Cf Memorandum on Vaccination against Smallpox. Memo 31./MED. Ministry of Health London 1948

craft's departure from an infected area was found to provide adequate protection

Although the incubation period for plague is not normally more than three days, it was recognized by the study group that it could sometimes be longer and attain or even exceed the six day period referred to in the conventions, especially in cases where infection is mild or alleviated by vaccination. However, it must be remembered that the length of the incubation period has lost a great deal of its importance from the international prophylactic point of view because of the efficiency of the new insecticides such as DDT

The possibility was also considered that since infection of ecto parasites takes place mostly during the last (septicæmic) stages of the disease, the marked curative action of sulfonamides and streptomycin may diminish the chances of secondary contamination

*

Another problem discussed by the study group was that of exanthematic typhus. It was agreed that the use of insecticides with residual action, such as DDT, should constitute, as in the case of plague, the essential measure of international protection against the disease and should permit the relaxation of other quarantine measures. In view of the danger of contamination by excreta of infected lice and fleas, disinfection as well as disinsectization of the effects of patients and contacts was recommended. For practical purposes, the incubation period of typhus was considered by the study group to be of 14 days, and not of 12 days as previously stated in the international sanitary conventions

A number of recommendations were also made by the study group with regard to louse borne relapsing fever, dengue fever, psittacosis, epidemic influenza, cerebrospinal meningitis, and poliomyelitis

First Session of the Expert Committee on International Epidemic Control

The findings of the three study groups⁷ were transmitted to the Expert Committee on International Epidemic Control,⁷ which met from 12 to 17 April 1948 in Geneva

The committee agreed with the study groups that protective measures taken by countries at their respective borders under

⁷For lists of participants see *Chronicle WHO* 1948 2 104-105

since it is in reality the expression of an antigen antibody reaction which does not necessarily imply that it is accompanied by immunity. This has been clearly demonstrated in cases of malignant smallpox in subjects re vaccinated a short while before who displayed the so called immunity reaction.

In conclusion, the study group felt that the time was ripe for making a decided change in the present quarantine system against smallpox. Article 42 of the Conventions of 1926 and 1944 left it to the authorities of the country of arrival to decide whether or not the traveller had been adequately vaccinated. The study group proposed, however, that all vaccination certificates which did not record a success or an accelerated reaction should be considered valid for six months only, while a doctor's statement, confirming that he had observed a reaction of either kind, should be valid for three years at least. Such a radical change may lead to satisfactory results, but implies also a fundamental change of principle.

The Expert Committee on International Epidemic Control, to which the question was referred, felt that the repercussions on national, as well as international, practice and legislation made it impossible to adopt the suggested change without further study. The final decision was, consequently, deferred to a later session.

Plague and Other Diseases

Although the time has not yet come for a general offensive against plague, the study group was in a position to make a number of recommendations which, if applied, might result in a considerable relaxation of the present quarantine measures.

The use of insecticides with residual action such as DDT was recommended as the chief measure of international protection against plague.

Recently developed rodent poisons were found to produce efficient deratization. The combined use of insecticides and rodenticides would permit, in the opinion of the study group, the eradication of plague from ports, towns and villages. It cannot, unfortunately, be of practical use in the fight against sylvatic enzootics.

It was agreed that disinsectization of merchandise coming from infected areas (as laid down under Article 17 of the 1926/44 Convention) should in some cases be supplemented by disinfection. In international air traffic, the proper use of insecticides on the air

Methods recommended for the Eradication of Malaria

In the report on its first session¹ the committee briefly outlined modern methods of malaria control, but the second session was chiefly devoted to the part that WHO could play in assisting governments

One of the most striking features of the report² of the second session held in Washington, 19-23 May 1948, is the evidence that it provides of the extent of the shift of emphasis from chemotherapeutic methods to mosquito control by the use of insecticides

The following is an account of the committee's main conclusions

Scope of Chemotherapy

Suppressive chemotherapy may be important as an emergency measure, especially during an epidemic, when the disease requires to be brought under control without delay. This should be done by treating the patients and by preventing the appearance of symptoms of the disease in subjects already infected by, or exposed to, anophelines. But thereafter, and as soon as possible, the vectors of the infection should be dealt with and a campaign against mosquitos should be organized

Against endemic malaria, clinical prophylaxis (suppressive treatment) duly controlled, should be applied collectively when it is impossible to take steps for the eradication of mosquitos, as in the case of groups of workers, schoolchildren and armies in the field. Moreover, the fact that individual clinical prophylaxis still plays a considerable part should not be overlooked

Choice of Drugs

Of the several available drugs

Quinine remains valuable, especially in the case of serious infections with malignant tertian malaria, it is not to be recommended for collective suppressive treatment, except in such countries as possess their own cinchona plantations

Atabrine³ is, without a doubt, an extremely efficacious suppressive, as experience during the second World War has shown. It

¹ Off Rec WHO 8 8 also extracts in Bull WHO 1947 1 23 32 and notice in Chronicle WHO 1947 1 101

² To be published in Bull WHO 1 No -

³ Synonyms: Acriquine Italcina Mepacrine Metoquina Quinacrine

existing international sanitary conventions were only palliatives, as effective international control of epidemics required delimitation of endemic areas whence epidemics of the pestilential diseases originated. It recommended, therefore, a delimitation of the endemic zones as a first step towards an eventual attack on these endemic foci with the technical help of WHO, if needed. The committee also considered simplification and improvement of the present system of disseminating urgent information on pestilential diseases, and particularly the possibilities of extending the present system of broadcasting telegraphic epidemiological bulletins.

Finally the committee decided to recommend the inclusion of louse borne relapsing fever among the pestilential diseases, and to recommend the inclusion of cerebrospinal meningitis, dengue fever epidemic influenza and poliomyelitis among the diseases for which immediate notification must be made in case of epidemic.

Control of Malaria

A Note on the Second Session of the Expert Committee on Malaria

Despite recent progress achieved in regard to malaria control, the incidence of the disease is still extremely high throughout a large portion of the globe. Millions of deaths and hundreds of millions of cases of malaria still occur annually. The reduced working capacity of populations physically and morally weakened by the disease has far reaching economic consequences. From its essentially rural character, malaria is perhaps, the scourge that most profoundly affects the agricultural worker, and hence the production of food as was stated before the committee by representatives of FAO. In regions already under cultivation, malaria undermines the strength of the workers and diminishes the number of effective working days—often during the harvest, when all manpower should be available. On the other hand malaria may prevent the development of regions where agriculture might have prospered. While the world is suffering from a shortage of food, and while the areas devoted to agriculture appear insufficient to meet all needs, the control of malaria in certain agricultural regions becomes an overriding necessity.

in rural areas. In urban centres, the use of the same insecticides for larval control may prove less costly.

A very large number of insecticides has already been studied with a view to use in the eradication of anophelines. DDT is the best of all, and provides ideal conditions for the control of malaria because of its relatively low cost, its prolonged residual action, and its relatively low toxicity for men and domestic animals, not to mention the additional advantage arising from the destruction of house haunting insects, other than mosquitos, which are liable to transmit infectious diseases.

The discovery of DDT resistant strains of house flies has given rise to some alarm. While no DDT resistant anophelines have hitherto been encountered, the possibility must be reckoned with, and the effect of that insecticide upon mosquitos should be carefully watched. Doubts have been expressed concerning the efficacy of DDT against the most dangerous of malaria vectors, *Anopheles gambiae*, in Central Africa. It is, however, difficult to express definite views on the matter, since further experiments are necessary.

The committee recommended that an expert sub committee on insecticides should be established to study all the questions still outstanding concerning the use of insecticides, and to establish international standards for insecticides and their formulations. This sub committee could also stimulate the distribution of the spraying apparatus that would be most suitable for each region.

The economic balance between production and consumption of DDT throughout the world appears to be satisfactory. But, paradoxically enough, DDT is manufactured mostly in non malarious countries, while those which are most in need of it do not produce it, and must import it, and the importer—in some cases, the Ministry of Health—is indeed often obliged to pay customs duty. It was recommended that all these questions should be referred to the appropriate bodies of the Economic and Social Council.

An International Policy of Control

There are three major technical obstacles to the worldwide use of new methods to control malaria: lack of organization of malaria control services, insufficient knowledge of new techniques and, finally, lack of trained personnel.

is a sure means of preventing falciparum infection, but has disadvantages which do not apply to paludrine and chloroquine

Chloroquine and *paludrine* produce the same results as atabrine, but are less toxic. The great advantage inherent in the e two drugs is that they can be used for short courses of treatment, sometimes of a few days. for suppressive purposes, one weekly dose is sufficient.

Treatment with chloroquine, which, according to trials in Venezuela, ensures radical cure of falciparum infections in only two days, would be most useful for outpatient treatment or self medication. the patient, who still feels ill after the first dose, is certain to take the second. whereas in the case of drugs which have to be taken over a longer period he may omit to continue the treatment once the symptoms have disappeared.

Paludrine is also suitable for self medication, for a single dose can be sufficient to cure an attack—even if only clinically. This drug has exceptional advantages as a causal prophylactic against falciparum infections and also partly against vivax infections. moreover, it has the property of arresting the cycle of development of the parasite in mosquitos so that the latter can no longer spread the infection. Investigations of the dosage and action of paludrine on different strains of the parasite should, however be pursued.

Relapses of vivax infection to day constitute a problem that is all the more acute because falciparum infection on the contrary, can be easily and completely cured by the use of the above mentioned synthetic drugs. As yet, only two methods exist to deal with vivax infection. to continue suppressive treatment for a very long period or to resort to combined treatment with a gametocide associated with a schizonticide—the old formula of plasmoquine combined with quinine in which nowadays pentaquine or iso pentaquine is substituted for plasmoquine. The latter two drugs which are less toxic than plasmoquine produce a very high percentage of radical cures, and iso pentaquine promises to be even more efficacious and less toxic than pentaquine. But both are as yet in an experimental stage.

Scope of Insecticides

Insecticides now make it possible to contemplate effective malaria control in most malarious countries. The residual method against adult mosquitos is the best evolved to date for large-scale control.

Research

In view of the gaps in present knowledge of certain aspects of chemotherapeutic drugs and insecticides the committee recommended the following programme of research

(a) Co-ordinated field and hospital trials in malaria therapy and prophylaxis in various countries and

(b) An experiment in the eradication of the vector species in a selected Central African region which must not be bounded or sheltered by natural barriers but artificially protected against the re introduction of the species by means of a campaign carried out at the periphery. The results of such an experiment would be of the highest importance in view of extension of anti malaria campaigns in Africa

Protection of Regions cleared of *Anopheles*

It is known that the eradication of the vector species is this year entering upon its final stages in two Mediterranean islands, Sardinia and Cyprus. With regard to the former the committee shared the Italian Government's anxiety to avoid the re importation of anophelines into the island once they have been eradicated. The Expert Committee on International Epidemic Control has sent the committee a draft international sanitary agreement and the committee has recommended to the World Health Assembly that measures similar to those provided for in the agreement be immediately enforced. It advised, however, that apart from the disinsectization of aircraft or ships, which may be left to the competence of the local authorities an essential protective measure be taken — rigid anti anopheline sanitation of ports and airports to ensure that no imported mosquitos survive.

The second session⁴ of the committee followed the Fourth International Congresses on Tropical Medicine and Malaria which were also held in Washington. Some seventy malariologists held an

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The following attended the session

Major-General Sir Gordon COVELL, Ministry of Health Malaria Laboratory, Horton Hospital, Epsom Surrey United Kingdom.

Dr A. GARCILÓO, Chief Malaria Division, Ministry of Health and Social Welfare Maracay, Venezuela (Chairman)

Aid to Governments

Since the objective of WHO is to aid governments as effectively as possible in carrying out malaria control by the most modern methods, it will have to direct its efforts as follows

(a) Assist governments on request to set up on a permanent basis control services suited to local needs and staffed by a suitably qualified and adequately paid staff. An essential condition for the effective control of malaria is that it shall be pursued at a cost which is the lowest feasible cost and proportionate to the budgetary capacity of the State concerned. To achieve this WHO may have to furnish individual experts to advise governments creating such a service or to improve existing services and lend operational demonstration teams to begin the work. These teams should first carry out a survey of the selected area and then carry out a control programme by means of residual insecticides. The co-operation of such teams would be granted on condition that each member of the team was undersupervised by a local colleague for it is understood that the programme of work of the teams shall thereafter be continued and developed by the host government.

The committee recommended that three of these teams be formed as early as possible and that they should be allocated on request from governments to selected areas in Central Africa South East Asia and the tropical Americas. These regions would be selected after due consideration by the Secretariat of WHO in co-operation with that of FAO on the basis of the feasibility of effective malaria control and of its importance as regard increased food production.

(b) Assist in existing school of malariology by sending foreign expert lecturers who would participate in the teaching programme and thus co-operate in the training of personnel offer fellowships and travel grants for training in malariology consider the possibility of a revival of the international malariology courses formerly held at Singapore by the Health Organization of the League of Nations and of organizing a similar course in Central Africa where there is a particular need of trained personnel.

(c) Promote knowledge of modern methods of malaria control by the dissemination of reports and manuals and by the circulation of material for the education of the public on this subject. When the regional organizations of WHO are established it would be well for these to create a service for lending educative material for malaria. The committee finally observed that the training of government officials and of engineers of all branches is even more important than education of the public.

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(Continued on following page)

ad hoc meeting during the Congresses.⁵ This meeting was arranged with the assistance of the International Conference Division of the Department of State of the United States, and through the good offices of Dr W Sawyer, Secretary General of the Congresses, as well as Dr Mark F Boyd, organizer of the malaria section.

Opinions were expressed, orally or in writing, concerning most questions on the agenda of the committee's second session. In drawing up its report, the committee has naturally taken note of the suggestions put forward. It considered itself fortunate in having thus been able to establish contact with the leading malaria control experts from many parts of the world, and to have had the benefit of their extensive experience.

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Karachi Pakistan

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Lumpur Malaya

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⁵ See p 157

The present shortage of insulin—an important problem now engaging the attention of WHO¹—is due not so much to a shortage of pancreas as to the failure to collect and treat all the glands obtained from slaughter houses

A discovery which may prove of great value in the conservation of pancreas glands has recently been made in Germany. In response to a request from WHO, Dr Fr Lindner, of the Biochemical Laboratory of Farbwerke Höchst, has kindly provided in the article below a description of the new method

Preservation of Pancreas-glands without Refrigeration

At present, and possibly for many years to come, the pancreas glands of slaughtered animals and of fish are the only source of insulin. During and after the war, insulin producers have had great difficulty in recovering their raw material, mainly because of the absence of appropriate refrigeration installations.

Unless the glands are processed without delay, or refrigerated at low temperatures (-20° to -30°C), their insulin content is rapidly lost. To find a means of preserving glands without refrigeration was therefore a problem of great importance.

After many unsuccessful experiments, a new process has been developed in the laboratories of the Farbwerke Höchst which answers these requirements². This process is based on the principle of converting the pancreas glands into a stable dry product by treating them with an anhydrous salt which binds their water content as water of crystallization. Anhydrous sodium sulphate is normally used for the purpose. As 142 grammes are required to bind 180 grammes of water, approximately 600 grammes of the salt are theoretically necessary to bind the water contained in 1 kilogramme of pancreas. In practice, however, 700 grammes are required. The dry preparation may be maintained at the degree of acidity required, for instance pH 5, by the addition of sodium hydrosulphate, tartaric acid, or any other suitable agent.

¹ Chronicle WHO 1948 2 53

² Application for German Patent No 75315 IV a/30 h filed on 21 June 1943

The idea of *dehydrating* an organ in order to preserve it is not new ³ But although the principle has already been applied by several workers to the preservation of pancreas ⁴, it has not so far yielded good results mainly because these workers failed to recognize that it was essential that the glands should be disintegrated rapidly and thoroughly and treated with an anhydrous salt not after, but during, the disintegration This process is most suitably performed in rapid cutting machines of the type found in most butchers' shops (fig 1)

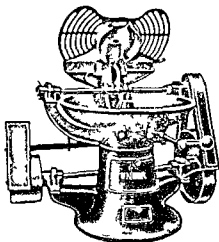


Fig 1

The cutter consists of a rotating dish with a set of rapidly revolving sickle shaped knives which simultaneously perform the disintegration and mixing, the pancreatic tissue being cut and its surface immediately brought into contact with the salt One of the advantages of this new method is that since it is simple and safe, it can be applied without special training by the personnel of slaughter houses

In a large cutter, 12 to 15 kilogrammes of glands can be processed at a time, and, in the smaller cutters commonly found in butchers shops 8 to 10 kilogrammes The glands should be collected and prepared as soon as possible after slaughtering, and then be kept in cold storage (5–8°C) until they are processed (not later than the same day) They are spread uniformly in the dish of the cutter and covered with 700 grammes of anhydrous, finely ground sodium sulphate for each kilogramme of pancreas The machine is then set in motion After 8 to 10 minutes a homogeneous and rather compact mass is obtained and placed on iron sheets in a layer about 5 centimetres thick The mass is then left for about one hour and taken into the refrigeration chamber for cold storage By the next morning the cakes will have solidified into slabs which are so hard and compact that they can be piled up without any special care

³ See Frankel in Abderhalden *Handbuch der biologischen Arbeitsmethoden* Hamburg, 1936-1940 Sect I part 6 p 4

See German Patent No 441614 and British Patent No 188660

If the batches are too large and processing is delayed difficulties are likely to arise, because the mass solidifies too rapidly.

The preparation obtained must be stored in as dry a place as possible at a temperature of 5 °C (cold storage). Under these conditions, even after six months in storage, no loss of insulin occurs. Even storage at normal room temperature—provided that it does not rise to 30 °C—is tolerated for several days without damage, which greatly facilitates transport.

Insulin is obtained from this preparation in the usual way with the same yield as is usually obtained from frozen glands.²

By applying the process described above, the Farbwerke Hoechst were able to double the number of slaughter houses from which they obtained the necessary pancreas glands for the production of insulin. It may be said that the new method has so far stood every test and has done much to stave off the worst consequences of the insulin shortage for diabetics in Germany.

² Some difficulties in centrifuging were experienced at the beginning owing to the high content of the preparation.

NOTES FROM THE FIELD

Greece

Anæsthetics

The recent visit of the Unitarian Medical Services Mission from the U S A which included amongst its members a Professor of Anæsthesiology has stimulated the desire for progress in this subject. There is no specialist in anæsthetics in Greece at the present time and open ether is generally the anæsthetists' choice. Certain surgeons have developed local anæsthetics to a considerable extent but the absence of experience and equipment together with the fact that nitrous oxide is not manufactured in Greece has prevented the development of modern techniques. Negotiations were going on early in June between the Faculty of Medicine Athens, the British Council, AMAG Public Health Division and WHO as to the ways and means of providing an experienced anæsthetist from abroad who would go to Greece for a period of not less than twelve months and conduct a systematic course in this speciality.

Orthopædic Surgery and Rehabilitation

At the end of May Dr Henry Kessler one of the most prominent American workers in orthopædic surgery and rehabilitation visited Greece by invitation of the Minister of War.

On his arrival Dr Kessler was engaged in lectures and demonstrations with some operative work chiefly though not entirely in the military hospital in Athens. The WHO field mission was asked to make arrangements for him in Greece. A brief though extensive programme was devised in co-operation with the Ministry of Health, the Faculty of Medicine and another medical institution.

Public Health Nurses' Graduation

On 19 May the first post war group of sixteen public health nurses received their final graduation diplomas in the presence of Her Majesty Queen Fredericka. Most of these nurses will remain in Athens and work in the health centres and hospitals there.

Malaria Control

Reports have been recently received from the WHO field mission in Athens that 1 554 villages have been DDT residual sprayed up to 1 June.

NOTES AND NEWS

More about Insulin Production and Consumption

Two further replies one from Argentina and one from Australia have been received by the Secretariat in response to a questionnaire concerning insulin supplies which was sent to governments late in 1947. The production in these two countries roughly suffices to meet their needs. Australia moreover supplies New Zealand. The new data do not therefore modify the relationship between the quantities of insulin available and insulin requirements as given in a previous number of this journal.¹

The position in these two countries is of great importance in view of their richness in raw material. Argentina exports 583 tons of frozen pancreas annually which is processed in other countries. Australia where about two million pigs are slaughtered annually intends to resort to collecting pig pancreas. A thorough study of methods of extracting insulin may facilitate extraction from sheep pancreas which is at present hampered by the high fat content of that gland in the sheep. If this could be done the twenty two million sheep that are slaughtered yearly in Australia² could be turned to good account.

The search for new sources of insulin has revealed the possibility of using whale pancreas. In the blue whale the pancreas is about 2.5 metres long and weighs about 70 kilogrammes. The gland of the small whale weighs about 35 kilogrammes.³

During the period 1933-1940 some 43 000 whales were caught yearly for the 1947-1948 whaling season the estimated catch is 25 000.

The extraction of insulin from cod pancreas recently attempted in Germany but abandoned by reason of its very high cost appears to be of interest to certain firms engaged in cod fishing and oil-extraction. These firms already possess the necessary technical equipment and may therefore be able eventually to reduce the cost and thus contribute to increase of supplies.

Informal Meeting on Malaria in Washington

An informal meeting attended by 70 malarialogists participating in the Fourth International Congresses on Tropical Medicine and Malaria was held on 13 May in Washington under the Chairmanship of Dr A. Gabaldon. The object of the meeting was to afford an opportunity to participants to express their opinion upon a series of technical problems relating to the activities which WHO could carry out in the field of malaria.

¹ *Circule WHO* 1948 2, 57

² Statistics for the years 1938-1942

³ One kilogramme of whale pancreas may yield about 1 000 units of insulin

According to Dr L W Hackett these activities should consist of exchanging technical information of fostering research in general of aiding research laboratories engaged in investigation of new insecticides and of studying the collateral benefits to public health which result from the application of the residual insecticide methods in malaria control

The importance of interchanging experts granting fellowships and supplying technical literature was emphasized by Dr M Pinotti who at the same time pointed out the necessity of stimulating the study of the bionomics of malaria carrying mosquitos in different parts of the world Dr H P S Gilette Dr W J Stoker and Dr J Clavero del Campo drew attention to the necessity for reducing the cost of DDT and of spraying equipment The problem of Central African malaria was stressed by Dr I Schwetz Professor C Macdonald supported by Dr D Baster Wilson and Dr I I Chwatt emphasized the importance of attempting an experiment in anopheline eradication in a selected region in Central Africa Such a region could be compared in their opinion to an artificial land because having no natural barriers it could be protected by a belt of residual insecticides An experiment of such nature might shed much light on the question of the anti malaria policy to be adopted in Africa

The group heard an interesting and clear statement by Dr C A Alvarado who on the basis of a large scale campaign carried out in his country showed that residual DDT puts the cost of malaria control below the level of the economic losses caused by the disease

Several other speakers drew attention to the opportunity for WHO of re-establishing international malaria courses

Visiting Lecturers in Poland and Finland

An international medical team jointly sponsored by WHO and the American Unitarian Service Committee is visiting a number of cities in Poland and Finland during July and August to describe and demonstrate some of the latest techniques in medicine and surgery The team headed by Dr Leo Davidoff Professor of Clinical Neurological Surgery at Columbia University College of Physicians and Surgeons is composed of six American professors who will be joined by British Czechoslovak Swedish and Swiss colleagues

The work of this international group the second of its kind to be organized by the Unitarian Service Committee under the sponsorship of WHO¹ will be concentrated for six weeks in the universities of Warsaw Krakow and Lönzán and in the Kosciuszko Hospital at Piekary Poland Following their activities in Poland the group will proceed to Finland for a two weeks stay at the universities of Helsinki and Turku

A number of medical specialities will be represented Particular emphasis will be placed on the various branches of surgery such as neurological surgery orthopaedic surgery and chest surgery in which notable advances

¹ For an account of the visit to Austria see *Chronicle WHO* 1947 1 113

have been made in recent years. In addition there will be specialists in general surgery, anaesthesiology, radiology and other subjects.

Other members of the mission are Dr W. Edward Chamberlain (radio logy, Temple University, Philadelphia, Pa.), Dr Joseph Charvat (medicine, Charles University, Prague), Dr Robert Elman (clinical surgery, Washington University School of Medicine, St. Louis, Mo.), Dr Eugene B. Ferris (medicine, University of Cincinnati, Ohio), Dr Samuel Z. Levine (pediatrics, Cornell University Medical College, New York), Dr James E. M. Thomson (orthopaedic surgery, Lincoln, Nebr.), Dr S. Bernard Wortis (psychiatry, New York University College of Medicine, New York), Mr C. Price Thomas (chest surgery, London), Dr Robert Mackray (anaesthetics, London), Professor Jean Good (Basle), Professor C. Crafoord (chest surgery, Stockholm) and Dr H. Good (pulmonary thoracic surgery, Basle).

Reports from Poland show that the first phase has been in outstanding success. Particular mention is made of WHO's success in obtaining for the mission the services of no less than three teams of thoracic surgeons at the urgent request of the Polish authorities. Mr Price Thomas was operating at the Wolski Hospital in Warsaw during the first two weeks in July and he has now been replaced by Professor Crafoord. Dr H. Good begins a course on pulmonary thoracic surgery at Poznan on 27 July.

Fellowship Programme of the Interim Commission

The fellowship programme of the Interim Commission of WHO, which began in the early spring of 1947, ended during the interim phase of the organization this June¹.

During its operation fellowships were granted to doctors and other health personnel of twelve countries, these being placed in practically every European country, in the United States and in Canada—countries in which the development of medical sciences and public health had continued during the war years or which had recovered since the end of hostilities and were able to share their experiences with others.

Two hundred and seventy-four fellowships were granted for study in the medical sciences, clinical subjects and public health. One hundred and fourteen fellows have now completed their studies and are already utilizing in their own countries their knowledge acquired during the study tours. One hundred and sixty are still studying or are awaiting transportation and these will conclude their fellowships under the auspices of WHO itself.

During the course of the fellowship programme a fellowship manual, based on actual experience, has been compiled and effective working relations have been established with other organizations dealing with fellowships, aiming at the most satisfactory and as far as possible uniform methods of administration.

Many new applications have been received by the New York and Geneva offices of WHO, the majority of them from fellows wishing to start in the

¹ For an account of the 1947 fellowship programme see *Chronicle WHO* 1948: 23. The programme from its inception to mid 1948 is described in *Off. Rec. WHO* 9.

autumn of this year. The chief characteristic of these requests has been the growing number of candidates for fellowships in nursing, public health, nursing, occupational therapy, midwifery, sanitary engineering and other branches of the large field of public health.

Resettlement of Specialists

From discussions at the General Conference on the Resettlement of Specialists (PCIRO) held in Cwatt, Switzerland, from 26 to 30 April 1948, which was attended by an observer of the Interim Commission, it appeared that the resettlement of nurses no longer presents any difficulties, the demand now being greater than the supply. As for doctors, although some progress has been made in the last six months, about 2,000 of them still await resettlement. Requests for small numbers of doctors have recently been received from Norway and Venezuela, but the greatest hope for rapid solution of the problem lies in the Bill now before the Congress of the United States of America to admit into that country 200,000 displaced persons outside the quota, with doctors given the second highest priority.

A register of available doctors, with their qualification after screening, is being produced and should be ready by July.

It was suggested that WHO should promote the standardization of the terminology of the various medical degrees issued by universities and assess their value in different countries.

Maternal and Child Health

Following a decision taken by the Interim Commission at its fifth session to include the subject of maternal and child health as an item of the highest priority in the provisional agenda of the Health Assembly, Dr. Erkki A. Leppo, Deputy City Health Officer, Helsinki, was appointed to the Secretariat of the Interim Commission as expert on this subject.

WHO Representation

During the period between 1 June and 1 July, the Interim Commission was represented by observers who attended or took part in the meetings of the following organizations:

General Assembly, Second Session, ICRO, Geneva, 1 June

Economic Commission for Latin America, Santiago, Chile, 7 June

First International Congress on BCG, Paris, Lille, 18-23 June

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

VOL. II, No 8-9

August September 1948

FIRST WORLD HEALTH ASSEMBLY

The Work

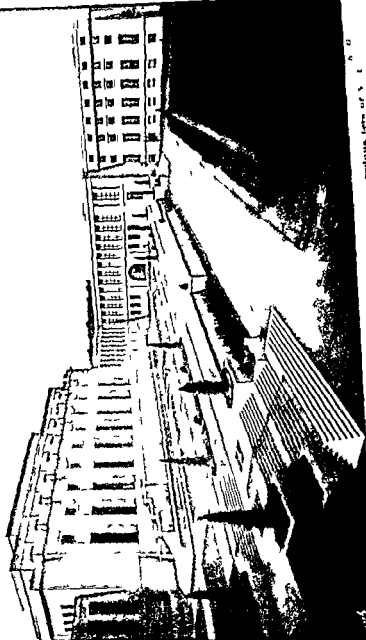
The first World Health Assembly, which met at Geneva from 24 June to 24 July 1948, has set the seal on the work begun by the International Health Conference, held in New York in July 1946, by giving final form to a single international medical organization. For the first time the term World appears in the title of an inter governmental organization.

Before the World Health Organization could come into legal being, its Constitution drawn up at New York in 1946, had to be ratified by 26 States Members of the United Nations. Legislative procedure in all countries is necessarily slow. The ratifications took place over a period of two years and it was not until April 1948 that the twenty sixth ratification gave legal existence to the new organization. In addition to these 26 ratifications, there were nine by States not Members of the United Nations.

During this period of waiting, an Interim Commission, established at New York in 1946, had the task of preparing the way for the definitive organization and of undertaking provisionally some of its more urgent tasks.

Immediately after the twenty sixth ratification the Interim Commission addressed itself to the handing over of its own authority, at the earliest possible moment, to the controlling bodies of the Organization: the World Health Assembly and the Executive Board.

The two year life of the Interim Commission was packed with activity. The Commission took over the functions of three of the four pre-existing international health organizations: the Office



1. I believe that the information is correct and that the person is a member of the group.



Photo L.V.

From left to right Dr Brock Chisholm first Director General of WHO
Dr Andrija Stampar President of the first World Health Assembly and
Professor Henri Laugier Assistant Secretary General in charge of Social
Affairs United Nations

International d'Hygiène Publique, the Health Organization of the League of Nations, and the Health Division of UNPRA. It established a headquarters office at New York, where several officials had the task of keeping in touch with the United Nations and its numerous commissions, and it set up a large European office, where most of the medical staff and other officials of the Organization worked. At the end of its term of office the Interim Commission thus had a staff of about 225. To meet the many problems, old and new, which arose after the second World War, it set up 19 expert committees and subcommittees, whose activities have been described in previous numbers of the *Chronicle*. In October-November 1947, the Interim Commission was able to offer its services to Egypt in the battle against the cholera epidemic raging there, and the

assistance provided to that country gave cogent proof of the value of international co operation in the medical field

On the basis of its experience, and having a thorough knowledge of the tasks with which WHO would be called upon to deal, the Interim Commission was able to submit to the Health Assembly concrete proposals concerning the structure of the Organization and its programme of work. These proposals were collected into a 150 page volume—No 10 of the *Official Records* of WHO—for discussion paragraph by paragraph and submission to the vote of the Assembly

Forty seven States were represented with full rights at the opening of the session on 24 June—21 having ratified between April and June. Seven more States joined during the early part of July, bringing the number of Member States to 54. A further 14 States took part in the work of the Assembly without the right to vote. The representatives of 66 States in all¹—Afghanistan and Transjordan being absent—thus brought to the debates on the future tasks and duties of the Organization, the suggestions, opinions and wishes of their governments

Election of President and Vice Presidents

Dr Andrija Stampar, President of the Yugoslav Academy of Sciences and Arts, who had been Chairman of the Interim Commission practically throughout its existence, and whose name has been associated for 25 years with the principal experiments of international co operation in public health, was unanimously elected President of the Assembly.² Rajkumari Amrit Kaur, Minister of Health of India, Dr C H de Paula Souza, Director of the Faculty of Hygiene and Public Health of the University of Sao Paulo, and Sir Aly Tewfik Shousha, Pasha, Under Secretary of State, Ministry of Public Health, Cairo, were unanimously elected Vice Presidents

The Committees

The agenda before the Assembly embraced a wide variety of questions—the shaping of the Organization's future activity, the

¹ For map showing membership of WHO and States represented at the first Health Assembly see p 168 for list of participants see p 210

² For biographical note of Dr Stampar see p 204



Photo WHO

Dr G. H. de Paula Souza
Vice President of the first
World Health Assembly

drawing up of its programme for the next few years, the choice of a permanent seat, the establishment of regional organizations, determination of the budget, election of the Executive Board and of the Director General.

Had all these matters been discussed in plenary session, the Assembly could not have finished its work within a month. It therefore distributed most of them among five main committees:

Committee on Programme (Chairman, Dr Karl Evang, Norway, Vice Chairman, Dr F. Castillo Rey, Venezuela), which was allotted the difficult

task of defining the Organization's field of action.

Committee on Administration and Finance (Chairman, Dr M. Kacprzak, Poland, Vice Chairman, Dr A. J. van der Spuy, Union of South Africa), whose work included the budget, the scale of contributions of Member States, and the staff regulations.

Committee on Relations (Chairman, Dr Melville Mackenzie, United Kingdom, Vice Chairman, Lt Col M. Jafar, Pakistan), which had the task of defining the nature of the relationships of WHO with the



Photo UN

Rajkumari Amrit Kaur, Vice President
of the first World Health Assembly

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Committee, and from among the delegates nominations for the chairmen and vice chairmen of the five main committees. As is generally known, very often in international conferences the elections take place on the basis of proposals submitted by the delegates in plenary session, but all preliminary negotiations are a matter of personal contacts. The new system has already been adopted by several organizations. Tried out by WHO, it yielded excellent results and it may be expected that it will be adopted in future by most international conferences.

Election of Executive Board

Immediately the Assembly began its work, it became clear that all questions could not be discussed in plenary session or by its committees, but that a number would have to be referred to the Executive Board.

Under the terms of the Constitution, this body consists of 18 persons designated by as many Member States. The Assembly selects, on the basis of equitable geographical distribution, the States called upon to designate a delegate to the Executive Board. It should here be noted that the members of the Board do not represent their countries, but the interests of the Members of the Organization as a whole. States are normally elected for a three year term, but in order to ensure that there would be six new Members annually, it was provided that out of 18 Members elected by the first Assembly, six should hold office for one year, six for two and six for the full term of three years. The term of each Member was decided by the drawing of lots.

The Executive Board will meet at least twice a year and on each occasion will determine the place of its next meeting. Its function will be to act as the executive organ of the World Health Assembly. Hence it is this body that will give effect to the decisions of the Assembly. Moreover, it has the important responsibility of submitting general programmes of work to the Assembly. It may also make proposals and advise the Assembly, either at the latter's request or on its own initiative. Finally, in cases of emergency—danger of epidemics, for example—it may authorize the Director General to take appropriate steps.

The powers of the Executive Board then, are considerable, for during the period between two Assemblies the Organization's destinies will be in its keeping.

United Nations, the specialized agencies, and with governmental and non governmental organizations

Committee on Headquarters and Regional Organization (Chairman, Dr J Zozaya Mexico, Vice Chairman, Dr E Ungar, Czechoslovakia) which had to select the town for the seat of the Organization's permanent headquarters and to demarcate the zones suitable for forming regional organizations

Legal Committee (Chairman, Dr J van den Berg, Netherlands, Vice Chairman, Dr F S Maclean, New Zealand), which had, amongst other matters, to discuss the legal aspects of international conventions and regulations

All the States Members of the Organization were entitled to be represented on each of these five committees. Working parties composed of a small number of delegates were set up to consider in greater detail questions which would have occupied the attention of the main committees too long. Into this category fell, for example, quarantine measures against malaria, maternal and child health, certain budgetary questions, and regional organizations. During the Assembly, several committees and working parties met simultaneously. Thanks to the flexibility of this machinery, much time was gained—a fact of considerable importance, for international conferences are extremely costly, and in the end it is the citizens of each Member State who through their contributions, however small, have to bear the cost.

A special body, the General Committee, co-ordinated the work of the main committees. It consisted of the President and the three Vice Presidents of the Assembly, the chairmen of the five main committees and the representatives of China, France, Siam, Syria, the USSR, and the United States of America.

A Committee on Credentials, consisting of nine members, met several times under the chairmanship of Sir Aly Tewfik Shousha, Pasha (Egypt), and had as Vice Chairman Dr E Ungar (Czechoslovakia). Finally, the formation of a Nominations Committee renewed an interesting experiment in international co-operation. It consisted of nine members under the chairmanship of Dr C Mani (India), its Vice Chairman being Dr M Kacprzak (Poland). Its task was to propose to the Assembly from among the heads of delegations nominations for the offices of President and the three Vice Presidents and for the members of the General



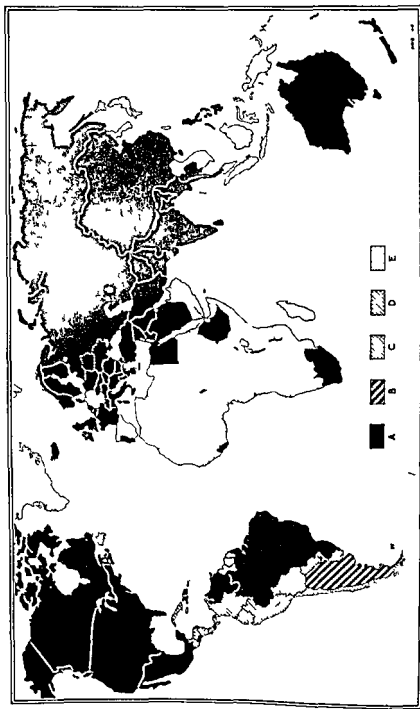
Photo J. Kernen Geneva

Centre Sir Aly Tewfik Shousha Pasha Vice President of the first World Health Assembly and Chairman of the Executive Board left Professor J. Parisot France right Dr M. Vauzel France

It will be readily understood that the election of 18 States empowered to designate the members of the Board was no easy task. Indeed, the principle of an equitable geographical distribution is more easily expressed in theory than in practice.

To avoid time consuming discussions in plenary session, the President of the Assembly placed the matter before the General Committee, which, after extended deliberations, achieved almost unanimous agreement on a list of 18 States. The Assembly adopted this list by 39 votes to 10, several delegates having expressed the opinion that the list was not so representative as it might have been. Eighteen States were thus elected, and they appointed, as members of the Executive Board, the following

- Dr G. M. Redshaw (Australia, one year)
- Dr G. H. de Paula Souza (Brazil, two years)
- Dr N. Lvstafiev (Byelorussia, three years)
- Dr S. T. Chellappah (Ceylon, one year)



A Members of WHO

B Accorded full rights of membership by the Assembly, including the deposit of the instrument of ratification



Photo J. Keraen Geneva

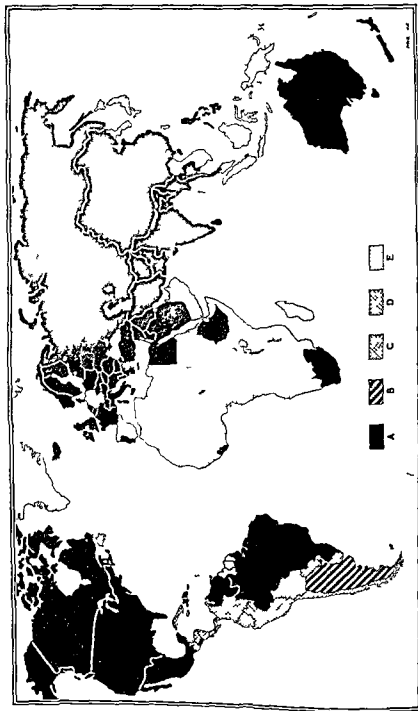
Centre Sir Aly Tewfik Shousha, Pasha, Vice President of the first World Health Assembly and Chairman of the Executive Board, left Professor J. Parisot, France, right Dr M. Vuocol, France.

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Members of WHO and Participants in the first Health Assembly



A Members of WHO
 B As ordered by the first Health Assembly
 C As ordered by the first Health Assembly
 D As ordered by the first Health Assembly
 E As ordered by the first Health Assembly

production Among the diseases which take the greatest toll of health and life are malaria, venereal diseases, tuberculosis, ankylostomiasis, filariasis, leishmaniasis, leprosy, schistosomiasis, trypanosomiasis, influenza, trachoma, cancer, etc

Experience in the Health Organization of the League of Nations clearly showed that certain diseases, such as cancer and leprosy, do not lend themselves easily to international action Nothing really useful can be done to fight these diseases at the present stage of medical knowledge, nor even to promote scientific research, which costs so much that the Organization's entire budget would be merely a drop in the ocean Confining itself, therefore, to diseases that can be efficiently controlled, the Interim Commission had unanimously agreed that malaria, tuberculosis and venereal disease should head the list Indeed, the new insecticides, such as DDT, and the new imagocide methods against malaria, streptomycin, BCG and modern methods for mass diagnosis and treatment of tuberculosis, sulfonamides and penicillin against venereal disease, justify the hope that international action, reinforcing the measures of national administrations, may diminish the ravages of these diseases It must not be forgotten that malaria strikes at hundreds of millions of persons each year and causes hundreds of thousands of deaths Its effects are most marked among rural populations, and thus it directly aggravates the world food shortage Tuberculosis and venereal diseases are worldwide problems

To these three diseases, which will receive particular attention, in the Organization's working programme, maternal and child health had been added at one of the last meetings of the Interim Commission on the proposal of the representative of the United States

These four subjects were given special priority at the head of the Assembly's agenda They were followed by thirty five other subjects with regard to which the Organization's activities must be on a more limited scale This conception of the WHO's work results from a compromise between two conflicting tendencies which had developed in the Interim Commission

According to one view, the Organization should confine its activities to a number of important health questions, working within a limited field in order to prove to the world that the health of the various populations can be improved by means of activities along certain clearly defined lines

Dr W W Yung (China, two years)
Sir A T Shousha, Pasha (Egypt, two years)
Professor J Parisot (France, two years)
Colonel C Mani (India, three years)
Dr M H Hafezi (Iran, one year)
Dr J Zozaya (Mexico, two years)
Dr K Evang (Norway, one year)
Dr C van den Berg (Netherlands, three years)
Dr B Kozusznik (Poland, three years)
Dr H S Gaur (Union of South Africa, three years)
Dr N A Vinogradov (USSR, two years)
Dr M Mackenzie (United Kingdom, one year)
Dr H van Zile Hyde (United States, one year)
Dr A Stampar (Yugoslavia, three years)

Sir Ali Shousha, Pasha, was elected Chairman,³ Dr K Evang and Dr W W Yung Vice Chairmen

Election of Director General

The first action of the Executive Board was to nominate Dr Brock Chisholm to the Assembly as Director General of the Organization. The Assembly adopted this proposal and Dr Chisholm, Executive Secretary of the Interim Commission, thus became the first Director General of the World Health Organization.⁴

FIELD OF ACTION OF THE ORGANIZATION

Malaria Tuberculosis Venereal Diseases, Maternal and Child Health

In drawing up recommendations for the Organization's programme of activities, the Interim Commission had been faced with the difficulty of determining what were the most important and urgent problems on the long list submitted for its consideration.

In every country of the world diseases exist and some have become such scourges that they undermine the health of the populations, reducing their capacity for work and curtailing national

³ See biographical note on Sir Ali Shousha Pasha p. 20

⁴ See biographical note on Dr Brock Chisholm p. 20

of BCG, and lack the qualified personnel required to apply present day methods of diagnosis and treatment. Nations producing new drugs such as antibiotics and sulfonamides, which need complex and expensive apparatus for their manufacture, are not always those with the most urgent needs. Nations impoverished by the war cannot afford the considerable expenditure involved in large scale imports of these drugs, quite apart from restrictions arising out of trade agreements. Numerous countries have no personnel conversant with modern techniques, and finally very often, the populations are ill informed or may even be ignorant of the course of development of a disease and of its consequences and of what modern science can offer for the relief of suffering and the safe guarding of health.

It is in these various ways that WHO can substantially complement its international activities, by helping governments to develop their national services and to organize their campaigns against disease on the basis of modern scientific methods. This can be done by the sending of experts and demonstration teams, the allotment of fellowships for the training of public health specialists, and finally by advice on education of the public and public health propaganda. The Organization also intends to exert its influence in order to render accessible to all countries, on terms that accord with their budgets, the means of combating infectious diseases.

The four programmes adopted by the Assembly, then, involve in the first place measures of assistance to governments, but provision has also been made for action of an international nature and for an extensive programme of study and scientific research.

The details of action on the international plane and of the programme of studies were laid down by the Assembly as follows

Malaria

Action on the international plane

- (a) Promotion of the production of insecticides and therapeutic agents, and improvement of their distribution,
- (b) Collection and distribution of technical information,
- (c) Development of international regulations,
- (d) Co operation with other organizations concerned with malaria,
- (e) Participation in relevant congresses and conferences

The other view was that the modest means at the Organization's disposal could not finance the control of even one disease. The Organization should, therefore, set itself the objective of establishing programmes embracing all health problems, in every country of the world. The Organization, which could not take direct action in all fields, should act as a sort of general staff in health matters.

These two points of view were defended with equal vigour in the Assembly. After much discussion, the Assembly decided that the Organization's activities should be mainly devoted to the four subjects mentioned above. But two further subjects were granted priority: nutrition and environmental sanitation (sanitary engineering).

What courses of action will be followed by WHO, and in what form will its aid be given? Although the methods of curing or preventing certain diseases may be universally known, they are not in practice accessible to every country. Those in which malaria is rife do not manufacture DDT, and have to import it. Countries in which tuberculosis is rife are without institutes for the preparation

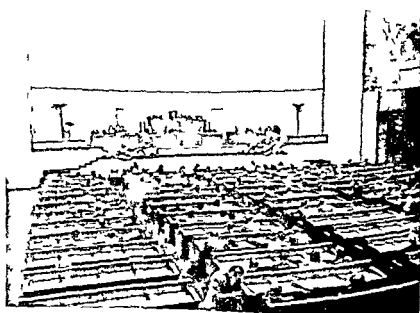


Photo J. Hernan Geste
The Assembly in plenary session

Investigations and studies on

- (a) The nature and extent of venereal infections, fluctuations in the morbidity and mortality caused by these diseases, factors affecting their spread value of the control methods in use,
- (b) Standardization of agents used in venereal disease control,
- (c) Production and distribution of penicillin and other therapeutic agents

Maternal and Child Health

Action on the international plane

- (a) Programme of co operation and joint action with organizations concerned with maternal and child health,
- (b) Collection and distribution of relevant information, including particularly the results of studies and research, of information on current procedures, methods and administrative practices, and the preparation of reports on maternity and child care, including standard techniques, methods and practices, and materials for use in health education programmes

Investigations and Studies on

- (a) Statistical and other research projects on the causes and the methods of reducing maternal, infant and childhood morbidity and mortality
- (b) Child guidance and mental health of children
- (c) Social aspects of maternity and health programme,
- (d) Facilities and personnel for providing maternity care and health services for children, including hospital and auxiliary services

The Organization, which will embark upon these four programmes in 1949 and develop them over succeeding years will have for each a specialized section forming a part of the WHO Secretariat, an expert advisory committee, and experts and teams employed on a temporary basis as required

Investigations and studies on

- (a) The extent of and trends in malarial prevalence and anopheline infestation
- (b) The factors affecting spread of malaria,
- (c) The relative value of available methods of control,
- (d) The efficacy of agents used in the control of malaria

Tuberculosis

Action on the international plane

- (a) Collection and distribution of technical information,
- (b) Development of uniform procedures and standards of tuberculosis control,
- (c) Co operation with other organizations concerned with tuberculosis
- (d) Participation in relevant congresses and conferences

Investigations and studies on

- (a) The extent of the problem and of available resources for control
- (b) The prospects and results of the campaign against tuberculosis,
- (c) The results achieved by the BCG vaccination campaign now being carried out by UNICEF

Venereal Disease

Action on the international plane

- (a) Development of international regulations, including the matters covered by the Brussels Agreement of 1924,
- (b) Stimulation of the production of penicillin and the improvement of its distribution
- (c) Collection and distribution of technical information,
- (d) Research grants to organizations or institutions capable of carrying to a definite conclusion the study of specific problems of venereal disease recommended by WHO,
- (e) Co operation with other international organizations contributing to venereal disease control
- (f) Participation in relevant congresses and conferences

Environmental Hygiene (Sanitary Engineering)

It has been estimated that more than one fifth of all deaths throughout the world are due to diseases arising out of environmental conditions. In the case of infantile diarrhoea the number of deaths attributable in large measure to an unhealthy environment has in some countries reached alarming proportions.

The list of diseases caused by inadequate destruction of waste matter—such as typhoid, bacillary and amebic dysentery, cholera, ankylostomiasis, schistosomiasis, etc. — is enough in itself to demonstrate the importance which environmental hygiene will have in the Organization's programme, an importance enhanced by the fact that control of these diseases on a worldwide scale need not await new knowledge nor the utilization of new methods.

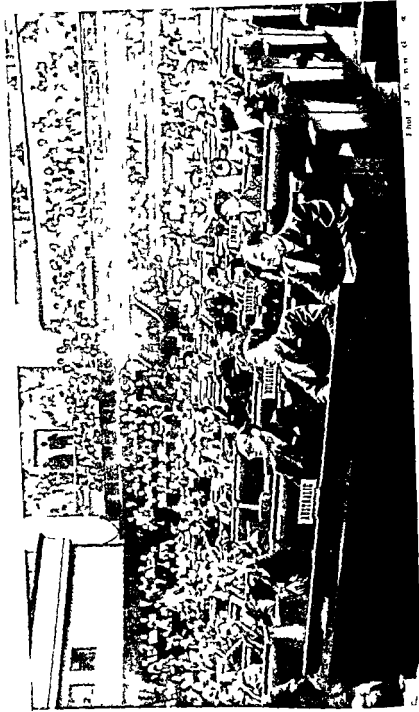
The World Health Assembly allotted to environmental hygiene a top priority ranking with those accorded to malaria, maternal and child health, tuberculosis and venereal disease.

An expert committee will be established at the earliest possible moment, and the Secretariat will include a specialized section whose work will include the study of improved sanitation and hygiene of urban and rural districts, together with problems of housing, town and country planning, and natural resources. In rural hygiene, WHO assumes a common responsibility with FAO and UNESCO, and it may be desirable to set up a joint committee.

In general, measures for the improvement of environmental hygiene can be taken by direct government action without recourse to the slower and more complicated methods of education, instruction, or individual treatment necessary in the case of other diseases, it may, therefore, be hoped that the Organization will obtain results such as could not be looked for in other fields without much greater expenditure.

Nutrition

Nutrition is the last subject on the list of the Organization's activities for the next few years. It is perhaps the environmental factor that has the greatest bearing upon health. During the last thirty years it has been realized that inadequate nutrition plays an important part in infant mortality and that it is responsible for the



The Assembly plenary was a

Photo of the day

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Ph 1 J 1 r n Geneva

Left Dr N A Barin Deputy Minister of Public Health of the Ukrainian SSR right Dr N A Vinogradov Deputy Minister of Public Health of the USSR

poor physical condition of many schoolchildren and adolescents, as well as for health defects in later life. For these reasons it was decided to request the co-operation of IAO in the establishment of a joint committee on nutrition.²

Furthermore, a specialized section on nutrition will be set up within the framework of the WHO Secretariat to study, inter alia, the questions of endemic goitre and pellagra.

² It will be recalled that a joint IAO WHO Committee consisting of doctors and nutrition experts met at Washington from 23 to 26 July 1947 to draw up at the request of the United Nations International Children's Emergency Fund a report on the general situation of children in war-devastated countries in Europe and in China. See *Chronicle WHO* 1948 - 6.

Other Medical Questions

The energies of the new Organization will then be largely devoted to the control of malaria, tuberculosis and venereal diseases and to maternal and child health, nutrition and environmental sanitation. This priority of certain tasks in no way implies that the other medical problems awaiting solution are forgotten or abandoned. It is simply the result of an attempt to demarcate the fields in which international action may be expected to yield the best results. The other subjects have been grouped under various headings.

Public Health Administration

Public health administration was given a second priority in the list of future activities of the Organization. This group comprises all problems relating to hospitals, clinics and nursing homes, medical aid, medical rehabilitation, medico-social activities, nursing, sanitary training, industrial hygiene and the hygiene of seafarers.

The setting up of an expert committee for nursing was considered necessary, but it is not contemplated for 1949 and the question will be reconsidered by the second World Health Assembly. Moreover, in consultation with the International Labour Organization two small joint committees will probably be set up to deal with industrial hygiene and the hygiene of seafarers. The section of the Secretariat which will deal with these questions will comprise one public health expert and one nurse.

The WHO can make a noteworthy contribution to all branches of public health. There is, to begin with, the vast task of organization of hospital services, a matter of the utmost importance to health authorities in war devastated countries. The only method whereby governments can be saved from misdirected effort is to enable them to benefit from the experience gained by other countries. Such exchanges of information cannot take place unless there is adequate international co-operation.

Medical aid for the population is a whole or for certain groups raises another fundamental question. There exist various kinds of organizations, ranging from benevolent organizations catering for certain specific groups to the uniform system functioning under State control and embracing the whole of the population. The legislative aspect of medical aid has engaged the attention of ILO and the International Labour Conference has on several occasions made recommendations in this connexion. Medical aid is also a

matter of the greatest interest to WHO, which, it is generally recognized, must be in a position, in co operation with other specialized agencies to undertake the necessary studies

The rehabilitation of persons disabled through the war or illness constitutes a relatively new aspect of public health organization to which increasing attention is being paid. It was considered desirable that WHO should be conversant with recent progress in a large number of countries and should be able to furnish relevant information if requested to do so

It is doubtless unnecessary to stress the importance of medical social activities and nursing in any medical plan. In progressive countries social workers employed as medical auxiliaries, are becoming increasingly important. Certain countries, however, have not enough social workers and nurses. There are a number of methods of recruiting qualified personnel, and the solution of this problem is often dependent, in a given country, upon the method adopted. For a long time the responsibility of supplying emergency assistance and first aid lay with the Red Cross Societies. The Health Organization of the League of Nations also interested itself in the professional training of public health nurses. The standards applicable in technical training to the determination of levels of proficiency, to specialization within the profession and to the organization of nursing services, are difficult problems for many States. It was therefore felt that they ought to be reviewed on an international level.

The Secretariat will study a proposal that WHO should recommend to all governments the establishment of a public health system or service organized in such a way that there would be, for every 30 000 inhabitants or—according to the density of the population—for every 50 000, a public health medical officer on a full time basis, for the control and direction of the health services of the region.

As for sanitary training, industrial hygiene and the hygiene of seafarers, the Organization will undertake studies and will furnish governments with information which will doubtless be of use in the organization of their services.

Parasitic Diseases

A third rank priority was given to several parasitic diseases, ankylostomiasis, filuriasis, leishmaniasis, schistosomiasis and trypanosomiasis. Several specialists will form a central committee

and will deal with these diseases, assisted by a group of experts

The Assembly has expressed the wish that schistosomiasis should be considered first of all. This parasitic disease, like malaria, incapacitates millions of persons in Africa, Asia and South America, especially in agricultural regions. The WHO will collect information on frequency, incidence and geographical distribution, and also on the measures of control undertaken and the economic consequences of the disease, and will furnish governments with a documentation as full as possible.

Filariasis has not yet been studied by an international group and the terminology and classification of this group of diseases shows great divergencies. The World Health Organization will collate and distribute the available information and promote a uniform classification.

Virus Diseases

Some virus diseases—poliomyelitis, rabies, influenza and trachoma—have received a fourth rank priority.

The Secretariat has been instructed to consider the possibility of stimulating the mass production of mechanical respirators (iron lungs), which could save the lives of numerous patients suffering from poliomyelitis. It has been suggested that every country should build up a reserve of respirators and that a system be worked out to enable a country, in case of an epidemic involving an increase in respiratory cases, to mobilize all available aid—respirators, experienced medical advisers and related personnel—from neighbouring regions or countries.

Fresh problems are presented by rabies, and these can be solved only through international co-operation. At the present time the value of anti-rabies treatment is being questioned, and an impression is gaining ground—particularly in certain countries—that in man vaccination may not be so effective as was first believed.

The first International Conference on Rabies, held in Paris in 1927, asked the Health Organization of the League of Nations to collect and publish statistics on anti-rabies treatment, in the hope that in this way information could be gathered concerning the most satisfactory method of vaccination. Although a great deal of information was collected (1 670,848 persons treated), the hopes of those who had initiated the investigation were not realized,

and experts from eight countries, who met at Bucharest in 1938, stressed the need of a second International Conference on Rabies.

It is, therefore, obviously important that the matter should be approached from another angle, but it would be well, beforehand, to form a comprehensive picture of the different aspects of the problem presented by the treatment for rabies, and this can best be done through an exchange of information among specialists.

A central committee responsible for virus diseases will devote special attention to the possibility of another international conference on rabies, and to the question of the advisability of extending the practice of vaccinating dogs, according to the method used with satisfactory results in Hungary before the war.

With regard to influenza, it will be recalled that the Interim Commission decided to establish an international centre to collect and disseminate information on the outbreak of epidemics and on the serological type of the virus responsible, to collect and distribute pathological specimens and to contribute to the technical training of specialized personnel*. This project must now be completed, and it is hoped that the International Influenza Centre of the World Health Organization will start its work before long, under the supervision of Dr C. H. Andrewes.

With regard to research on trachoma, active co-operation will be maintained with the main research institutes concerned with the problem and fellowships will be given for study in such institutes.

Mental Health

Mental health is a relatively new subject of international co-operation. It is only within the last 30 years that the influence of the psychic factor on health has been generally recognized. The International Health Conference held in New York in 1946 unanimously agreed that the new World Health Organization must, *inter alia*, foster activities in the field of mental health, especially those affecting the harmony of human relations and, in its attention to maternal and child health, foster the ability to live harmoniously in a changing total environment. These words connote a long term programme and a concern with the subject which must extend over several generations.

* See *Chronicle WHO* 1947 1 1-4



The Assembly in plenary session

The World Health Assembly, which gave to mental health, including alcoholism and drug addiction, a fifth rank priority, did not feel that more definite plans should be made, in view of the imminent meeting of the first International Congress on Mental Health⁷, which would advise upon the most urgent tasks and the most promising lines of action in this field, but the Assembly instructed the Executive Board to consider such recommendations of the International Congress for Mental Hygiene as may be made to WHO and to take such interim action for their implementation as it may find to be desirable. A committee of experts will be set up to study questions related to mental health.

Habit forming Drugs

An expert committee will be established within the next few months as a consultative body to WHO and the United Nations. There is a fundamental difference between the functions of the Expert Committee on Mental Health, which will, *inter alia*, deal with drug addiction, and the Expert Committee on Habit forming Drugs. The latter will be composed of pharmacologists, as provided under the agreements with the United Nations, and will give advice on habit forming drugs with a view to their control as provided under the 1925 and 1931 conventions⁸.

World Production of Penicillin

WHO will take steps to stimulate the production of penicillin and to improve its distribution throughout the world.

Negotiations were opened with UNRRA, with a view to transferring to WHO the penicillin factories and the funds required to complete the UNRRA programme in regard to penicillin production. There are now penicillin factories, established by UNRRA, in Byelorussia, China, Czechoslovakia, Italy, Poland, the Ukraine and Yugoslavia.

The World Health Assembly authorized the Secretariat to institute a worldwide inquiry on penicillin requirements and production.

Inherited Functions

In addition to the programmes already discussed, the Organization inherits certain functions from previous international health

⁷ To be reported in a subsequent issue

⁸ See *Chronicle BHO* 1947 1 166

organizations the Office International d'Hygiène Publique, the Health Organization of the League of Nations and the Health Division of UNRRA

International Epidemiology

The WHO will modify international sanitary legislation to bring it into line with new conditions, and collect information on pestilential diseases and quarantine measures, which it will distribute as rapidly and widely as possible among national health administrations and port health services. An expert committee will be set up which will serve the Organization in a consultative capacity. Epidemiological information will be disseminated by telegraph, as in the past, as well as by the publication of the *Weekly Epidemiological Record* at Geneva and the *Weekly Fasciculus* at Singapore. Fuller information will be given in the monthly *Epidemiological and Vital Statistics Report*, the contents of which, in summarized form, appear regularly in the *Chronicle*.

Control will also be exercised in other fields of international quarantine, especially in the demarcation of yellow fever endemicity areas, the approval and checking of yellow fever vaccines, the delivery of national yellow fever vaccination certificates, measures to be taken in case of infringement of the conventions and international vaccination certificates.

The expert committee for the formulation of technical recommendations will be established as soon as possible under the title of the Expert Committee on International Epidemiology and Quarantine of the World Health Organization. The Interim Commission's Expert Committees on Quarantine and on International Epidemic Control will thus be merged into a single body. This new committee will include a subsection on quarantine and will have the services of a legal subcommittee, a panel of experts on yellow fever, and joint study groups on cholera, smallpox and vaccination, and other epidemiological problems. It will have to deal with epidemiological questions in their entirety, and its principal task will be to study, in the light of recent scientific knowledge, the existing international sanitary conventions—those of 1926-1944 on maritime navigation, of 1933-1944 on aerial navigation, and other conventions of lesser importance—and to combine them into a single set of regulations on the sanitary measures applicable to travellers. These

various regulations will form a chapter of the International Public Health Code. An Expert Committee on Plague, which is shortly to be set up, will assist in the work. Finally, a small committee of three experts with broad knowledge of insecticides and their uses will be constituted, its members will preferably be representatives of the more important national insecticides committees. This committee will have the benefit of the services of a panel of experts possessing specialized knowledge of the following subjects—two or three experts for each subject

- (a) Chemistry of insecticides,
- (b) Disinsectization of aircraft,
- (c) Mechanical devices for such disinsectization,
- (d) Dusting and vaporization devices,
- (e) Dusting by aeroplane,
- (f) Insecticide application in houses

The services of one or several experts appointed by WHO, or of an expert belonging to the Division of Epidemiology of the Secretariat, will be at the disposal of the governments. These specialists will act as consultants at the request of any country, will give advice on the putting into effect of the sanitary conventions and regulations and will if necessary, visit the country concerned to deal with these questions.

Finally, the Health Assembly recommended that in case of major epidemics, WHO should be considered by the Member States as the first of the sources of assistance open to the countries concerned.

Biological Standardization and Unification of Pharmacopœias

The work of the Interim Commission Expert Committees on Biological Standardization and on the Unification of Pharmacopœias has been described in previous issues of the *Chronicle**. This work will be continued by a WHO Expert Committee on Biological Standardization assisted by subcommittees on antibiotics, antigens, blood groups, vitamins, hormones and others, as circumstances require, and also by a WHO Expert Committee on the Unification

* *Chronicle WHO* 1947 1: 77, 103, 149; 1948 2: 116.

of Pharmacopœias Two specialized sections will be set up in the Secretariat

Health Statistics

Health statistics receive probably the least attention in modern public health science Health administrations, clearly, need reliable information, unfortunately, in a large number of countries, such information is lacking, and where it does exist it is not comparable with the data of other countries, because of differences in definition and in the methods employed On the other hand, in national and international health activities, morbidity statistics are not utilized to the full as a source of information Finally, insufficient data are available on certain aspects of chronic diseases, such as incidence, mortality rate, survival rate, effectiveness of treatment, etc

Health questions are of such diversity that statistics are necessary in determining the magnitude of problems and in working out plans of action, or assessing the effectiveness of measures taken It has therefore been decided that a WHO Expert Committee on Health Statistics will shortly be established, assisted, if necessary, by temporary subcommittees A Health Statistics Section will be established within the Secretariat

The Organization will try to help governments by furnishing them with health statistics from different countries, as well as fellowships and specialists to demonstrate the practical use of the *International Statistical Classification of Diseases, Injuries and Causes of Death*, and by supplying expert advice on health statistics On an international level, WHO will organize the decennial revision of the International Lists of Diseases and Causes of Death, will establish international regulations on the compilation and publication of health statistics and will furnish statistical aid for research work in special fields of health, such as work on cancer morbidity and the BCG vaccination campaigns

Publications

The publications of WHO, in addition to their essential function as vehicles of information, will form the main link between the Organization and professional health workers

They will be for national administrations, a basic source of official information on the Organization's work, and will keep medical research workers posted on WHO's scientific activities

The programme of WHO publications for 1949 includes the following

- (1) *Bulletin of the World Health Organization*, replacing the *Bulletin of the League of Nations Health Organization* and the *Bulletin mensuel de l'Office International d'Hygiène Publique*. It will publish technical articles on questions dealt with by WHO and its expert committees
- (2) Technical supplements to the *Bulletin*, and monographs—the latter for work of too specialized or too detailed a character for the *Bulletin*, including special subject bibliographies, international pharmacopœia, a *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death*, a monograph on cancer treatment statistics, international list of treatment centres for venereal diseases (under the Brussels Agreement), and a monograph on modern methods of treatment of venereal diseases
- (3) *Chronicle of the World Health Organization*
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- (6) *Weekly Epidemiological Record*
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- (8) *Epidemiological and Vital Statistics Annual*
- (9) *Weekly Fasciculus* of the Singapore Epidemiological Intelligence Station
- (10) *Annual Report*, Singapore Epidemiological Intelligence Station
- (11) An epidemiological telegraphic code (Codepid)
- (12) *International Maritime and Aerial Quarantine Handbook(s)*

Regional Organization

The health questions arising in the different parts of the world are so varied and often so closely bound up with local conditions—climate, culture, etc.—that it might well be difficult for a central organization to have a detailed knowledge of them all and to be fully aware of the various requirements. Therefore, the Constitution of WHO¹⁰ provides for the establishment of regional organizations serving geographical regions, which the World Health Assembly had the responsibility of demarcating.

Each of these regional organizations will form an integral part of the Organization and will comprise a regional committee and a regional office. They will consist of Member States and Associate Members¹¹ of the region concerned.

The regional organizations will be provided with the necessary authority to issue directives on all questions of a purely regional character. They will exercise their prerogatives through technical conferences which they may organize, and especially through the regional offices which will be the administrative organs of the regional committees.

The division of the world into several regions on the basis of sanitary and epidemiological criteria was discussed at length by the Assembly, which finally decided upon the early establishment of five regional organizations to serve the following regions:

- 1 *Eastern Mediterranean Area*, comprising the following countries: Egypt, Saudi Arabia, Iraq, Syria, Lebanon, Palestine, Transjordan, Yemen, Iran, Turkey, Pakistan, Greece, Ethiopia, Eritrea, Tripolitania, British Somaliland, French Somaliland, Aden, Cyprus.
- 2 *Western Pacific Area*, comprising the following countries: Australia, China, Indochina, Indonesia, Japan, Korea, the Philippines, New Zealand, and, provisionally, the Malay Peninsula.

¹⁰ Chapter VI, see *Chronicle WHO* 1947, 1, 36.

¹¹ Territories or groups of territories which are not responsible for the conduct of their international relations may be admitted as Associate Members by the Health Assembly upon application made on behalf of such territory or group of territories by the Member or other authority having responsibility for their international relations. (Article 8 of the Constitution)

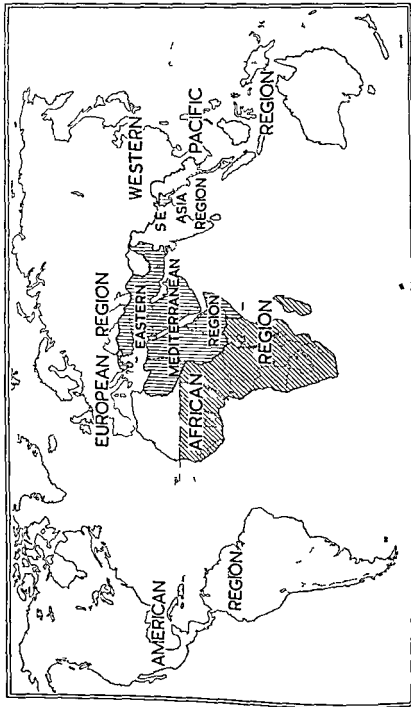
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- 3 *South East Asia Area*, comprising the following countries Burma, Siam, Ceylon, Afghanistan, India, the inclusion of the Malay Peninsula to await the definite decision of that region as to which regional organization it desires to join
- 4 *European Area*, comprising the whole of Europe
- 5 *African Area*, a primary region is suggested for all Africa south of the 20 degree N parallel of latitude to the western border of the Anglo Egyptian Sudan, to its junction with the northern border of the Belgian Congo, thence eastwards along the northern borders of Uganda and Kenya, and thence southwards along the eastern border of Kenya to the Indian Ocean
- 6 *American Area* It is known that all the States in the Americas, with the exception of Canada, belong to the Pan American Sanitary Organization which, since 1902, has successfully contributed by its efforts to the raising of the health level of its member countries. In accordance with Article 54 of the Constitution, the Pan American Sanitary Organization will be integrated with WHO through common action based on mutual consent of the competent authorities expressed through the organizations concerned

With several proposals before it, the Assembly discussed the necessity for establishing regional organizations in some or all of these areas during the year 1949. It decided that each of the regional organizations should be constituted as soon as the majority of Member States of the regional area in question had agreed to participate in it. In the Eastern Mediterranean region the existing regional organization, the Sanitary Bureau at Alexandria, is to be integrated with the Organization at the earliest possible moment. Finally, for Europe, a special administrative office will be established as soon as possible, on a temporary basis, to concern itself with the health rehabilitation of war devastated countries in that region.

Proposed regional organization of WHO



- (k) Rehabilitation of patients ,
- (l) Extermination of tuberculous cattle

Venereal Diseases

The Health Assembly recommended that governments take—subject to the conditions in their countries—preventive, curative, legislative, social and other measures necessary for venereal disease control, particular attention being paid to the following

- (a) Notification of primary and secondary syphilis , declaration of sources of infectious contacts , and national and international contact tracing ,
- (b) Systematic pre marital and pre natal examinations, including serological tests for syphilis ,
- (c) Comparative study of antigens and sero diagnostic methods in syphilis on the national and international plane ,
- (d) Establishment of optimum standards of treatment, and making such treatment available to all, with special reference to the importance of preventive treatment of syphilis in pregnancy ,
- (e) Compulsory treatment of persons suffering from communicable venereal diseases and compulsory hospitalization of those who refuse to submit to treatment

Maternal and Child Health

The Health Assembly recommended that governments take—subject to conditions in their countries—preventive, curative, legislative, social and other measures necessary for the protection of the health of mothers before, during and after confinement, as well as for the welfare and upbringing of children, drawing special attention to

- (a) Protection of the health of adolescents—particularly girls—and expectant and nursing mothers who are employed in gainful occupations, and the prohibition of the gainful employment of children ,
- (b) Introduction of leave of absence for expectant mothers, and leave after the birth of the child, with the continuation for the duration of leave of adequate wages ,

Recommendations by WHO to the Member States on Tuberculosis Venereal Diseases, Maternal and Child Health and Malaria

The WHO will devote most of its resources to the control of malaria, tuberculosis and venereal diseases, and the health care of mothers and children, but these efforts are obviously destined to fail unless the Organization secures the effective support of the medical profession and the health administration in each country. Hence, WHO has not confined itself to establishing the four programmes outlined earlier in this issue, but has also formulated technical and legislative recommendations for all Member States.

Tuberculosis

The Health Assembly recommended that governments take—subject to the conditions in their countries—preventive, curative, legislative, social and other measures necessary for tuberculosis control, particular attention being paid to the following:

- (a) Registration of every case of confirmed and suspected tuberculosis and of death from tuberculosis,
- (b) Availability of institutional treatment available to all who require it, regardless of ability to pay. If such institutional treatment is not possible, treatment at home with adequate isolation,
- (c) Tracing and control of contacts,
- (d) Establishment of clinics for free diagnostic examination and follow up,
- (e) Examination of all tuberculosis suspects,
- (f) The securing of a sufficient number of beds in tuberculosis hospitals,
- (g) Routine tuberculin testing, free of charge when necessary,
- (h) BCG vaccination, free of charge when necessary,
- (i) Mass radiography, free of charge when necessary,
- (j) Compensation for the lowered earning capacity of the afflicted person.

vities malaria, tuberculosis, venereal diseases, maternal and child health, nutrition and environmental hygiene

Another sum of about \$700,000 will be set aside for fellowships, medical literature and teaching material

Considerable appropriations have been made for numerous other WHO activities, such as international epidemiology, editorial and reference services, public health administration, health statistics, etc

Permanent Headquarters of WHO

Geneva was unanimously selected as WHO's permanent headquarters. The Interun Commission, whose headquarters were at New York, but which had a large European office at Geneva, had examined the relative advantages of certain cities

Geneva has a central position in Europe and excellent communications with the rest of the world. The spirit of peaceful international co-operation which has long distinguished Switzerland, and particularly Geneva, and the traditions of fruitful work inherited from the League of Nations Health Organization, had a large measure of influence on the Assembly's choice

Agreements with the United Nations UNESCO, FAO and ILO

The draft agreements between WHO and the United Nations, UNESCO, the Food and Agriculture Organization, and the International Labour Organization were adopted by the World Health Assembly

Relations with ICAO

There will be no agreement governing the relations between WHO and the International Civil Aviation Organization. Relations between the two organizations have always been excellent and it was felt that it would not be wise to have them crystallized in the form of obligations inherent in an agreement which, by its very nature, would lack elasticity. This is a new departure in international relationships, and if the results achieved are as satisfactory as is hoped, agreements with other international organizations may one day be abrogated and a new system universally adopted

- (c) Access to adequate attendance for mothers during the birth of the child, both at home and in hospital, especially in the case of artificially aided births,
- (d) Organization of non governmental and governmental institutions where adequate medical consultation on pregnancy hygiene, and on feeding, care and upbringing of children can be made accessible to families

Malaria

Parallel recommendations concerning malaria were referred by the Health Assembly to the Executive Board for more detailed consideration

Adoption of draft International Regulations for Health Statistics

On the recommendation of its Legal Committee, the Health Assembly unanimously adopted a series of articles referring to the publication of statistics dealing with diseases and causes of death. These regulations were drawn up last May by an expert committee of the Interim Commission.¹² Their approval was, without a doubt, much the most important step taken by the Legal Committee. With the adoption of these regulations, WHO has made an important advance in international co operation, for this is the first time that an international organization has established legislation in the province of health.

By the terms of Articles 21 and 22 of the WHO Constitution, the regulations adopted will be internationally binding upon the State Member immediately and without the necessity of national legislation. Exceptions are made only in the case of Members who make reservations within a specified period and notify the WHO of such reservations or rejections.

Budget of WHO

The budget of the Organization for 1949 amounts to \$5,000,000. A sum of approximately \$950,000 has been allocated to the six subjects which have priority in the list of the Organization's activities.

¹² *Chronicle WHO* 1948 2: 116

vities malaria, tuberculosis, venereal diseases, maternal and child health, nutrition and environmental hygiene

Another sum of about \$700,000 will be set aside for fellowships, medical literature and teaching material

Considerable appropriations have been made for numerous other WHO activities, such as international epidemiology, editorial and reference services, public health administration health statistics, etc

Permanent Headquarters of WHO

Geneva was unanimously selected as WHO's permanent headquarters The Interim Commission, whose headquarters were at New York, but which had a large European office at Geneva had examined the relative advantages of certain cities

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The following extracts indicate the diversity of the views expressed during the Assembly. Many of the questions evoked discussions of some length, and the points at issue were vigorously debated. Nevertheless, the very difference in the angles of approach proved of value in the ultimate achievement of satisfactory solutions, and nearly all the decisions were in fact unanimous.

Points from Speeches

Dr A Stampar Yugoslavia — An outstanding feature of the philosophy of public health so ably conveyed by many of the delegates present has been the trend towards regional activities and the establishment of regional offices.

*

Sir Wilson Jameson United Kingdom — I look forward to provision by the Organization of a first class information service and of expert guidance over a wide range of subjects. This will stimulate all of us to set our own houses in order and to share our experience for the common good.

*

Dr Karl Erang Norway — We have just in this Assembly with heavy hearts I hope passed a budget of five million dollars. The Interim Commission had carefully and cautiously prepared its programme and then asked for at least six and a half to seven million dollars. The Programme Committee of this Assembly adopted the programme on general lines with some amendments which would have normally increased the budget. In spite of that it was cut.

I am not surprised at the lack of imagination and vision expressed in this drastic cut in the first year of the World Health Assembly. The rather miserable way in which human beings have conducted their world affairs in the last decades does not indicate a very high degree of imagination and vision and there is no reason why we here as a group should display a higher average standard of these most desirable qualities. What to my mind is surprising is the lack of realism and of practical sense of which this decision carries proof. We are public health people not representatives of treasury departments. We know that action is needed and we know that we cannot convince anybody unless we take action. To take action you have to be an operating agency—to go out into the field and do the work and we are being invited to do so by very eager and anxious regional offices all over the world.

*

Dr C van den Berg, Netherlands — These regulations [concerning International Health Statistics] in accordance with Article 22 of our Constitution will come into force for all Members after due notice has been given of their adoption by the Health Assembly except for such Members as may notify the Director General of rejection or reservations within the period stated in the notice. This means that for the first time in the history of the world an international legislative body is acting here with the possibility of adopting regulations which can come into force without formal acceptance by the countries

*

Dr N Vinogradov, USSR — The League of Nations Health Organization and the Office International d Hygiene Publique in Paris instead of liquidating the endemic foci were principally concerned with the creation of sanitary barriers. The liquidation of endemic foci and the saving of many thousands of people in territories stricken by epidemics have been replaced by pitiful palliative measures

*

Dr F L Soper, Pan American Sanitary Organization — The American republics are greatly interested in the World Health Organization but are most anxious that its activities be decentralized in so far as possible on a regional basis

*

Dr G H de Paula Souza, Brazil — I should like nevertheless to point out a fact which is characteristic of our country—namely the prestige accorded to the heads of our social health and sanitary reconstruction services. Their efforts are often supported by the public who are gradually becoming conscious of their responsibilities in regard to the health of the community. The names of Oswaldo Cruz and Carlos Chagas to name only two of the most famous who are already lost to us are known and respected as much as those of any great national heroes

*

Dr Simonovits, Hungary — The Hungarian Government fully shares the conviction expressed in the Constitution of the World Health Organization that the deterioration of public health in no matter what region means a common danger to the whole world. It is imperative therefore that public health problems be dealt with on an international level

*

Dr J Bantur, Philippine Republic — Let us not forget that no less than 70 per cent of the success of public health measures as shown by a study conducted some years ago by members of the United States Public Health Service depends upon the co operation of the people

*

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•

Sir Wilson Jameson United Kingdom — There is certain to be a temptation to tackle the big scourges of mankind but before embarking on any such undertaking we must be sure that the problem really does lend itself to international effort It may well be that it can be dealt with more satisfactorily on a national basis The Health Organization of the League of Nations studied this question most carefully and we would do well to take note of its findings

*

Dr T Parran, United States of America — The interest of our people was expressed in the unanimous action the unanimous vote of both houses of our Congress in accepting the Constitution of the World Health Organization Immediately thereafter the Congress appropriated the full amount of money estimated as necessary to cover the United States contribution to the World Health Organization for the current year including our estimated share of the Interim Commission's indebtedness and the establishment of its working capital fund

The President of the United States in signing the legislation providing for United States membership expressed for himself and for the people the intent of the United States Government in regard to the World Health Organization in the following sentiments

In view of the long history of effective international co-operation in the field of health we can look to the World Health Organization with hope and expectation

While performing its humane service it will at the same time contribute to general economic improvement through the progressive development of healthy alert productive manpower The world economy is seriously burdened and unnecessarily so by malaria tuberculosis and other controllable diseases

The World Health Organization can help to contribute substantially to the attainment of the healthy vigorous citizenry which the world needs so badly today and tomorrow

I am proud to have signed this joint resolution

through the World Health Organization we once again testify to our faith in the United Nations as the great instrument for reaching those goals of common understanding and mutual helpfulness among nations which alone can lead to peace and security for all peoples

*

Dr N Vinogradov, USSR — As long as it [prostitution] exists the growth of venereal diseases is inevitable If the World Health Organization intends to deal seriously with their control it cannot and must not close its eyes to the social root of this evil The Organization must consider the liquidation of the conditions which facilitate the spread of venereal diseases—such as discrimination against women in employment inequality or absence of rights for women household women and children and it must collaborate in maternity welfare social insurance and so on

*

Dr N Lystafiev Brelorussia — In those cases where the government of this or that country is in a difficult position and cannot study the reasons for the high infant mortality alone and work out a programme of action the World Health Organization of course with the agreement of the government concerned should assume responsibility for this work. In such case it would be very useful to send special experts and missions but this must without fail be accompanied by the dispatch of medicine literature and if necessary foodstuff

*

Prof J Sigurjonssen, Iceland — Although the immediate causes of the excessive deaths among infants in many countries are more or less well defined diseases the all important underlying causes are mostly of an economic and sociological character. Without improving economic conditions and raising the general standard of living the establishment of welfare centres on a small scale is bound to be of limited value. It is hardly within the power of the World Health Organization to improve directly the economic state of countries but we may hope that it may help indirectly to do so by stimulating national governments and assisting them in the organization of sanitary work and public education

*

Prof J Parisot France — We believe for our part that it would be highly desirable for the World Health Organization to give its full support to scientific institutions in various countries encouraging them to work on important problems and to co ordinate their efforts. Far from being diminished thereby the Organization's authority would be greatly enhanced

*

Dr J N To-ba Liberia — In embarking on world health service let us not just follow the old trails of UNRRV or other organizations or foundation but rather create new ones in order to equalize things throughout the world. Let us get to the source of the vectors of the various diseases and subdue them there

*

Dr N Vinogradov USSR — What are to be the fundamental tasks of the Organization in years to come? In our opinion they should comprise in the first instance assistance to nations which have suffered from the war: diminution of the effects of the war on health co operation in the fight against epidemics and a strengthening of international relations in the field of science

*

Dr Stampar was born in 1888 in Drenovac and studied medicine at the University of Vienna. In the first World War he was interned for four years during the occupation of Serbia. From 1919 to 1931 he was Director of Health in the Yugoslav Government. Then after travelling in the United States and China until 1932 he was visiting professor at several European universities and institutes of hygiene. From 1933 till 1936 he was associated with the League of Nations as a health expert attached to the Chinese Government and in 1936-37 with the League of Nations Health Organization as an expert on rural health.

In 1938 Dr Stampar returned to the United States as a visiting professor. In 1939 he became Rosenberg Professor at the University of California and was subsequently appointed to his professorship at Zagreb University.

He is the author of many scientific works including *Health and Society* and *Social Medicine*.

Sir Aly Tewfik Shousha, Pasha
Chairman of the Executive Board

Sir Aly Tewfik Shousha Pasha, Chairman of the Executive Board of the World Health Organization, was born in Cairo on 17 August 1891. He received an M.D. degree at the University of Berlin in 1915 and specialized in the study of bacteriology at the University of Zurich. He first worked voluntarily and was later appointed Assistant at the Hygienisches Institut in Zurich.

On his return to Egypt he served as a bacteriologist in the State Laboratories. In 1924 he became Deputy Director of the Egyptian State Laboratories and in 1930 Director General. In 1939 he was appointed Assistant Under Secretary of State in the Ministry of Public Health and in 1940 was appointed to his present post of Under Secretary of State in the Ministry of Health.

Many articles by Sir Aly Tewfik Shousha Pasha on bacteriology including immunology and other subjects have appeared in English, German and Arabic scientific journals. He is a member of the Linguistic Academy of Egypt, Chairman of the Egyptian Bacteriological and Pathological Society and Honorary President of the Egyptian Public Health Association.

His many decorations include the Nile Order (Egypt 1936) and the Medal of the United States Typhus Commission (1944). In 1946 he was made Commander of the Order of the British Empire and in 1948 Knight Commander.

Dr Brock Chisholm
Director General of the World Health Organization

Dr Brock Chisholm, Director General of the World Health Organization, was born in Oakville, Ontario, on 18 May 1896. He volunteered for military service during the first World War at the age of 18 and was able to complete his studies only after the end of the war, receiving his degree of Doctor of Medicine from the University of Toronto in 1924.

Lt Col M Jafar, Pakistan — It is common knowledge that compared with those of western countries the standard of living and expectation of life in Asian countries are deplorably low. It is therefore necessary that special care should be bestowed on countries which lack the resources possessed by the more advanced and prosperous countries of Europe and America. Unless that is done this Organization will not be acting up to the principles recognized by the United Nations as basic to the happiness, harmonious relations and security of all peoples.

*

Dr V Bardos, Czechoslovakia — I should like to restate here briefly the work to which we feel the World Health Organization should attend. Firstly it should act as a clearing house that is it should collect, analyse, interpret and disseminate information and knowledge relating to the health of nations and individuals. Secondly the Organization should promote and where appropriate recommend national and international action with respect to medical research and to the improvement of education and the administration of health services and the spread of public knowledge related to it. Thirdly the Organization should set up special committees to fulfil more effectively the tasks enumerated in points one and two with respect to special important diseases. Fourthly it should take steps to deal with emergencies whenever applicable and necessary and with the consent and co-operation of the nations concerned.

*

Dr A Stampar, Yugoslavia — We have now finished these weeks of strenuous work in which we have established the World Health Organization as a going concern. The fact that the Organization has thereby become one of the largest specialized United Nations organizations in existence testifies to the fact that our considerations and may I say vision at the International Health Conference in New York two years ago were founded on a sound evaluation of the future potentialities in the field of international health.

*

BIOGRAPHICAL NOTES

Dr Andrija Stampar

President of the First World Health Assembly

Dr Andrija Stampar, Chairman of the Interim Commission for virtually the whole of its two year existence, was elected President of the first World Health Assembly by acclamation on 24 June. Possessing a broad experience in the practice and teaching of public health both internationally and in his own country Yugoslavia, he is Rector of Zagreb University and Professor of Public Health and Social Medicine and was recently elected President of the Yugoslav Academy of Sciences and Arts.

Prompted by the urgent need of putting into effect at the earliest possible moment WHO's six medical programmes which will be operated on a world scale in 1949, the Board forthwith nominated expert committees to advise the Organization on tuberculosis, malaria, venereal diseases and maternal and child health. A similar decision was taken in respect of the Interim Commission's expert committees on the unification of pharmacopœias, on habit forming drugs and on biological standardization. These groups, as well as a small BCG committee and a committee on insecticides, will meet before the second session of the Executive Board, which opens 25 October in Geneva.

To enable the Board to devote its fullest attention to the numerous decisions of the Assembly, the first session's agenda was kept to an absolute minimum. Several important matters were held over for the second session.

Among these was the setting up of regional organizations to deal with health questions pertaining to certain geographic regions. However, on the request of the Czechoslovak delegation, supported by eight other European countries, the Executive Board decided to establish, from 1 January 1949, a special administrative office for Europe to assist in the health rehabilitation of war devastated countries.

In view of the great need of these countries, the setting up of this temporary administrative office will take precedence over the establishment of regional health organizations for the Eastern Mediterranean, Western Pacific, South East Asia and African areas. The Czechoslovak Government has informed the Executive Board that it would welcome the establishment of this office in Czechoslovakia.

Another important decision authorized the Director General to take all necessary steps to ensure close co-operation with several specialized agencies of the United Nations which have asked for assistance in various matters relating to public health. Among these, the International Labour Organization will receive expert advice on industrial hygiene and the hygiene of seafarers, and the Food and Agriculture Organization will be given assistance on nutrition questions. Joint committees will be set up, composed of members of WHO and of each of the other specialized agencies. Furthermore, WHO will co-operate with UNESCO in its pilot project on education in Haiti and in the co-ordination of medical congresses and of medical and biological abstracting services.

Dr Chisholm then did postgraduate work at several hospitals in England among them the Middlesex the London and All Saints Hospitals in London. During the period 1925-1931 he was engaged in general medical practice at his native Oakville. In 1931 he accepted a post on the staff of the Institute of Human Relations at Yale University and subsequently was connected with the National Hospital for Nervous Diseases, Queen Square, London and with the Maudsley Hospital, London. In 1934 Dr Chisholm returned to Canada and practised psychological medicine in Toronto until 1940.

During the second World War Dr Chisholm became an Area Commandant then in succession Director of Personnel Selection, Deputy Adjutant General with rank of Major General and Director General of Medical Services, a post which he held from September 1942 to November 1944. He was then appointed Deputy Minister of Health in the Department of National Health and Welfare, Canada, which position he held until July 1946 when he was elected Executive Secretary of the Interim Commission. He became Director General of WHO on 21 July 1948.

Among other posts held by Dr Chisholm was that of Chairman of the Canadian Medical Procurement and Assignment Board (1942-44). He was President of the Canadian National Committee for Mental Hygiene and Chairman of the Health Committee, Canadian Youth Commission (1943-46) as well as member of many medical societies among them the Ontario Medical Association, the Canadian Medical Association and the American Society for Research in Psychosomatic Problems, American Psychiatric Association and American Psychological Association. He is also a member of the Menninger Foundation and an associate editor of *Psychiatry*.

Dr Chisholm was made Commander of the Order of the British Empire in the New Year Honours List of 1943. He is also the recipient of the Lasker Award for Outstanding Contribution to Veterans' Rehabilitation.

He is the author of the William Alanson White Memorial Lecture 1945 and *Morale* 1940 and of many articles in technical and non technical journals.

FIRST SESSION OF THE EXECUTIVE BOARD

(Geneva, 16-26 July 1948)

The first session of the Executive Board, held from 16 to 26 July 1948, was devoted to putting into effect the most urgent of the decisions just taken by the first Health Assembly.

Under the chairmanship of Sir Aly Tewfik Shousha, Pasha, the Board reviewed the list of priorities in WHO's programmes recommended to it by the Health Assembly, and took the necessary steps for their implementation. The greater part of its remaining time was devoted to ensuring a sound administrative basis for the Organization's activities.

Prompted by the urgent need of putting into effect at the earliest possible moment WHO's six medical programmes which will be operated on a world scale in 1949, the Board forthwith nominated expert committees to advise the Organization on tuberculosis, malaria, venereal diseases and maternal and child health. A similar decision was taken in respect of the Interim Commission's expert committees on the unification of pharmacopœias, on habit forming drugs and on biological standardization. These groups as well as a small BCG committee and a committee on insecticides, will meet before the second session of the Executive Board, which opens 25 October in Geneva.

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The conclusion of the Board's first session was marked by a proposal from the Institut Pasteur, Paris, inviting WHO to make use of the Institut's numerous laboratories throughout the world, for the pursuit of research work on communicable diseases

NOTES AND NEWS

WHO Representation

During the period between 12 July and 17 September WHO was represented by observers who attended or took part in the meetings of the following organizations

Eighth session Executive Board UNESCO Paris 12-17 July

Seventh session Economic and Social Council Geneva 10 July

Congrès des Médecins électro radiologistes de langue française Geneva 28 July

General Council International Union of Child Welfare Stockholm 10-16 August

Centennial Medical Week Budapest 4-12 September

Ninth International Congress of Industrial Medicine London 13-17 September

Recent and Forthcoming Meetings

30 September	Expert Committee on Tuberculosis Paris
5-7 October	Joint OIHP WHO Study Group on Plague and Rickettsial diseases Paris
9-11 October	Joint OIHP WHO Study Group on Trachoma Paris
13-15 October	Joint OIHP WHO Study Group on Cholera Paris
18-19 October	Joint OIHP WHO Study Group on Smallpox Paris
15 October	Expert Committee on Venereal Infections Paris
15 October	Expert Committee on the Unification of Pharmacopœias Geneva
21-22 October	Joint OIHP WHO Committee Paris
22-23 October	Working Party of the Standing Committee on Administration and Finance of the Executive Board on allocation of residual UNRRA funds Geneva
25 October	Executive Board second session Geneva
11-12 November	Joint UNICEF WHO Committee Paris
15-20 November	Expert Committee on International Epidemiology and Quarantine Geneva
January (tentative)	Expert Committee on Maternal and Child Health Geneva
March-April (tentative)	Subcommittee on liposoluble vitamins London
March-April (tentative)	Expert Committee on Biological Standardization London

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LIST OF STATES PARTICIPATING IN THE FIRST WORLD HEALTH ASSEMBLY

* Delegates

† Alternates

§ Counsellors and experts

Albania

Mr B Shtylla
* Dr S Klossi
* Mr V Nathanail

Argentina

Dr A Zwaneh
§ Dr G Galvez Bunge

Australia

Dr G M Pedshaw
* Mr B C Ballard
* Mr W G A Landale

Austria

Dr F Reuter
* Dr F Puntigam
* Mr K Strobl

Belgium

Dr A Verbist
* M L A D Geeraerts
* Dr M de Laet
* Dr J Spaey
† Baron C van der Bruggen
† Dr P van de Calseide
† Dr F Goossens
§ M F Blondeel
§ Dr I van Hoof
§ Dr J Rodbain

Brazil

Dr G H de Paula Souza
* Dr A C de Almeida e Castro
* Dr P F de Berrero Carneiro

Bulgaria

Dr D Mateeff
Dr S Stoyanoff

Byelorussian Soviet Socialist Republic

Dr N Evstafiev
* Dr N Petrov

Burma

Dr U ba Maung

Canada

Dr G D W Cameron
Dr G F Amyot
* Dr T C Routley
§ Dr A Frappier
§ Mr J G H Halstead
§ Mr L A D Stephens

Ceylon

Dr S F Chellappah

China

Dr S N Cheer
* Dr C K Chu
* Dr W W Yung
† Dr C Y Shu
§ Mr Y S Chen
§ Dr K Cheung

Czechoslovakia

Dr E Ungár
* Dr V Bárdoš
* Dr B Schöber
§ Mr J Po pišl

Denmark

Dr J Frandsen
* Dr O Andersen
* Dr J Holm
§ Mr N C Rasmussen

Dominican Republic

Mr M Pastoriza

Egypt

Sir Aly Tewfik Shousha Pasha

* Mr H A Baghdadli

* Dr M Nazif Bey

El Salvador

Mr A Amy

Ethiopia

Mr A G Zallaka

† Dr F Hvlander

Finland

Dr O Reimikainen

* Dr T I Putkonen

* Dr K H Sarkko

France

Dr J Parisot

§ Dr F J Y Aujalen

§ Dr L Bernard

§ M P Bertrand

§ Dr A Cavaillon

§ Dr A R Dujarnic de la Riviere

§ Mme Catherine Labeyrie

§ Dr G Montus

§ M P M Raffard

§ Dr M Vaucel

Greece

Dr A Orfanidis

* Dr S B Briskas

Hall

Mr A Addor

Hungary

Mr J Vihol

* Dr S Simonovits

† Dr G Petenyi

† Dr S Tarska

† Mr B Veszpremy Bangha

Iceland

Dr J Sigurjonsson

India

Rajkumari Anrit Kaur

Sir A I Akshmanawansa Mudalra

* Dr C Mani

† Sir Dhiren Mitra

† Lt Col G L Pasricha

§ Dr S C Sen

§ Lt Col J Singh

Iran

Dr G Ghani

* Dr M H Hafezi

* Dr J Modjtchedi

Iraq

Dr S Zahawi

Ireland

Dr J A Deeny

* Dr J D MacCormack

† Mr J T Brady

Italy

Dr M Cotelessa

* Dr C A Canaperia

* Baron G V Confalonieri

† Dr S Cramarossa

† Mr F Malfatti

† Dr V Puntoni

Iberia

Dr J N Togba

* Dr A S Schnitzer

Mexico

Dr A P Léon

* Dr J Zozaya

§ Mr J C de Werra

Monaco

M M Izo

* Dr F Boeri

Netherlands

Dr C van den Berg

* Dr C Banning

* Dr W Aeg Timmerman

† Dr N A Roozendal

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- Dr J Spaey
- † Baron C van der Bruggen
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CHRONICLE OF THE WORLD HEALTH ORGANIZATION

VOL II, No 10

October 1948

STREPTOMYCIN IN TUBERCULOSIS

First Meeting of the Subcommittee of Streptomycin
30-31 July 1948, New York City

The Subcommittee on Streptomycin¹ of the Expert Committee on Tuberculosis held its first meeting on 30 and 31 July 1948, in New York City

¹ The following members were present

Professor K. Choremis Director Children's Clinic University of Athens Greece
Professor C. Cocchi Director Clinic of Pediatrics University of Florence Italy
Dr R. Cruickshank Director Central Public Health Laboratory London United Kingdom

Dr M. Daniels Farm Laboratories National Institute for Medical Research (Medical Research Council) London United Kingdom

Dr R. Debre Professeur à la Faculté de Médecine Directeur de la Clinique médicale infantile Hôpital des Enfants-Malades Paris France

Dr R. Du Bois Professeur de Pédiatrie Université Libre de Bruxelles Belgium

Dr H. C. Hinshaw President American Trudeau Society Mayo Clinic Rochester Minn. United States of America

Dr H. McLeod Riggins Chairman Chemotherapy Committee American Tuberculosis Society New York City United States of America

Dr H. E. Hilleboe Commissioner of Health New York State Department of Health Albany N.Y. United States of America member of the Expert Committee on Tuberculosis of WHO acted as Chairman of the meeting

The following American guests were invited to attend the clinical meetings so as to provide the foreign members of the subcommittee with information concerning the principal investigations going on in the United States at the present time

Dr J. Barnwell Veterans Administration Washington D.C.

Dr R. Dubos Rockefeller Foundation New York City

Dr F. Feldmann National Institute of Health Washington D.C.

Dr F. P. Fowler jr Otolaryngologist New York City

Dr K. S. Howlett Loral Heights Sanatorium Shelton Conn.

Dr Edith Lincoln Bellevue Hospital, New York City

Dr E. Medlar Bellevue Hospital New York City

Dr J. Perkins National Tuberculosis Association New York City

Mr W. Steenken Saranac Laboratory Saranac Lake N.Y.

Dr S. Willis State Sanatorium N.C.

Dr M. V. Veldee National Institute of Health Bethesda Md.

The recommendations which resulted from this meeting were referred to the Expert Committee on Tuberculosis, which adopted them and decided in its turn to submit them to the Executive Board meeting in Geneva on 25 October. It is only after approval by the Executive Board that the report of the Subcommittee on Streptomycin will be available to the Member States and the public.

The group of experts emphasized that streptomycin, while being useful in the treatment of several forms of tuberculosis, is, at its best, only a part of the general treatment in most forms of the disease and is partially dependent for its full effect upon other more common therapeutic measures, such as bed rest, pneumothorax or chest surgery. It is generally known that even under the best therapeutic conditions, severe toxic manifestations occur, some of them fairly frequently. Furthermore, tubercle bacilli in certain patients acquire resistance to streptomycin which eventually necessitates termination of specific therapy. It was therefore recommended that during the initial period of study and use streptomycin should be distributed by governments only to institutions and medical centres regularly concerned with the diagnosis and treatment of tuberculosis. With such safeguards limited supplies will be beneficially employed under the supervision of physicians experienced in streptomycin therapy, aware of its dangers and contra-indications and prepared to carry on further research on the more precise use of this and other newly developed antibiotics against tuberculosis.

Types of Cases suitable for Treatment

Streptomycin was not found to be suitable for all types and stages of tuberculosis infection.

It was unanimously agreed that patients with tuberculous meningitis and generalized hematogenous or miliary tuberculosis should be given prior consideration, because of the extremely high mortality rate among untreated cases and the lack of any other dependable therapeutic approach.

It appeared that fulminating types of bronchopneumonic pulmonary tuberculosis of recent origin, which have not progressed beyond the possibility of healing may frequently be ameliorated by streptomycin. Residual lesions of a more chronic and destructive character may require other forms of treatment.

Fig 1 — Subcommittee on Streptomycin New York 1948



From left to right sitting at the table Professor Cherems Professor Cocchi Professor Debra Dr McCord Higgins Dr Hilleboe Dr Daniels Dr Hinshaw and Professor Du Bois Extreme right Dr Cruckshank

Some of the most distressing complications of pulmonary tuberculosis, especially tuberculous laryngitis and tuberculous enteritis may be greatly benefited symptomatically by appropriate streptomycin treatment

Finally, streptomycin was found to be particularly effective in the treatment of tuberculous sinuses and fistulae, less favourable results have so far been reported in renal tuberculosis and in tuberculosis of bones, joints and glands

Regimens of Treatment

Optimum streptomycin regimens for the different forms of tuberculosis have not been determined with sufficient precision to make exact recommendations possible at this time. At the present stage of knowledge, the medical practitioner cannot expect to be provided with a universally accepted formula but will have to make his own choice from several regimens recommended by various

research workers. The group of experts could therefore hardly do more than define certain general principles to be observed in the application of streptomycin therapy. Thus, it was suggested, among other things, that in certain cases when the disease changes for the worse, or when a relapse occurs, a subsequent or second course of streptomycin may be indicated, provided that the tubercle bacilli have not become predominantly streptomycin resistant. The indications for a second course of treatment cannot, in the present state of knowledge, be specified precisely, but must be determined after careful review of all clinical and laboratory data in each case. There was, in the opinion of the group, some evidence that combined therapy (streptomycin plus sulphone derivatives or para-aminosalicylic acid) may be more effective in some forms of tuberculosis than either drug used alone. At the present time, combined therapy shows greatest promise in the treatment of military tuberculosis and tuberculous meningitis.

Plans for the Future

Perhaps the most outstanding contribution of the subcommittee was a strong recommendation that the Expert Committee on Tuberculosis establish a uniform record system for analysis and evaluation of streptomycin studies throughout the world. This will require joint planning and collaboration by experts in the fields of epidemiology, biostatistics, and public health in addition to the services of clinicians experienced in the use of streptomycin.

The experts were unanimously of the opinion that it was not sufficient to record data accurately for each study. It was necessary to have agreement on diagnostic criteria for each form of tuberculosis treated and especially for tuberculous meningitis and military tuberculosis. It was also important that an agreement shall be reached on methods of isolation of tubercle bacilli and of testing for streptomycin resistance in tuberculosis.

These were a few of the preliminary steps to be taken before it was possible to proceed with the maintenance of comparable records on the pathology and histology of treated cases that end fatally—an essential undertaking if new knowledge is to be gained for future use. The National Institute of Health of the United States and the Medical Research Council of Great Britain have already made great strides in developing uniform record systems for the study of

streptomycin in the treatment of tuberculosis and it was suggested that this material could be used as a basis for the establishment of uniform record systems including diagnostic and prognostic criteria, to be used in all future studies

It was recommended that the following information should be included in any report on the results of chemotherapy in tuberculosis

1 Selection of group

(a) Age distribution of cases Results related to age

(b) Type and stage of disease

For example in tuberculous meningitis the distribution of patients at different stages of illness on admission should be given and the results in these groups a statement should also be made concerning limitations on acceptance of advanced cases for treatment if cases dying within the first weeks are excluded from the main analysis brief particulars of them should be given

2 Duration of symptoms and course of disease before treatment was begun

3 Diagnostic criteria

Cases not proved bacteriologically by culture or guinea pig inoculation should be excluded from the main analysis and reported separately

Indication should be given of criteria (other than bacteriological) which were used for diagnosis of tuberculous meningitis and military tuberculosis

4 Duration of observation

The date on which the report is made and the date of admission of the last patient in the series should be given in order to indicate the minimum period of observation of survivors (A report should not include all cases admitted up to the time of reporting) The period of observation should be not less than six months

An ideal method is to report the condition of patients at definite periods of time after admission thus for meningitis analysis could be made of results at one month three months six months one year and two years after admission If more cases have been lost a statement should be made to that effect

5 Clinical and laboratory findings at the time of reporting should be given for each case

6 Cases of tuberculous meningitis with or without military tuberculosis should be reported separately from cases of military tuberculosis without meningitis at the start of treatment

It was also recommended that WHO encourage and facilitate international co-operative study in this field, by

- (a) donation of supplies of streptomycin for experimental use in clinical centres of research
- (b) organizing and supporting at the earliest practicable moment exchange of information cultures of certain strains of the tubercle bacillus and of new antibiotic drugs giving promise of therapeutic value
- (c) exchanging expert personnel among biological and clinical research centres in Europe and America

It is principally by such means that there will be created a continuing mechanism of inter communication among nations

The foundation for future conferences on the use of streptomycin and other antibiotics and drugs in the treatment of tuberculosis was thus established. It is expected that the next meeting of the subcommittee will be held in one of the European medical centres so as to enable its members to observe the results of experimentation with streptomycin in Europe

INTERNATIONAL CONGRESS ON MENTAL HEALTH

Nothing is more obvious than the disorders which have no other manifest cause than in the passions of the mind and likewise how far the dispositions and affectations of that [the mind] will go in the removal of a great many ill habits

JOHN QUINCY, 1712

The above words appeared as one of the commentaries of John Quincy in his translation into English of the *Medicina Statica* of Santorio. They represent a point of view which, over two centuries later has been universally accepted, and is embodied in the Constitution of WHO, although it is also widely realized that the logical consequences of this point of view are not yet reflected in medical education or in the organization of health services

At the Twelfth International Congress of Psychology, Professor F. D. Adrian the distinguished neurophysiologist, said that neurologists, neurosurgeons and physiologists were working on one side of a high wall and the psychologists on the other.¹ This present inability to correlate physiological and psychological concepts is doubtless responsible in part for the failure to give practical effect

¹ *Brit med J* 1954 2 113

to the growing body of knowledge of the influence of emotional factors on health. In recent years, however, it has become increasingly evident that such factors strongly influence not only the personal health of the individual, but also his relationships with his family, his employer or employees and all the men and women with whom he comes in contact. An understanding of the mental life and development of the individual from earliest infancy is therefore essential to an understanding of social affairs, not only in the family and at the office or workshop, but also in the wider spheres of political life and international relations. In the present state of knowledge, the study of human relationships must be based largely on the observation of effects, and the world cannot await the results of more academic studies on the nature of mental phenomena expressed in terms of experimental science.

The sciences concerned with mental health derive from intensive first hand studies of human beings and their interrelationships in various cultures of normal and abnormal development of normal groups and institutions and of the pathology of group functioning. The fields of work from which knowledge has been acquired include health and social services, education and industry, community organizations, the defence services and public administration.²

Considerations such as these led, early in 1947, to a decision by the International Committee on Mental Hygiene to hold an International Congress on Mental Health, the main theme of which was to be Mental Health and World Citizenship. Apart from the intrinsic importance of its subjects, this Congress was a remarkable experiment in international and interprofessional co-operation. The Congress was held in London from 9-21 August 1948, and was preceded by a meeting of an international preparatory commission which carried out an intensive programme of study and discussion from 24 July to the eve of the Congress.

From 1947, a vast amount of preparatory work had been undertaken by committees and study groups working in twenty-seven countries. More than three hundred such study groups worked for periods up to, and in many cases more than, a year in preparation for the Congress. The study groups were in most cases widely representative of the various aspects of mental health such as psychiatry, social psychology, social anthropology, sociology,

² International Congress on Mental Health, London, August 1948. Statement by International Preparatory Commission, pp. 10-11.

education, religion, social work and law. Each of these groups made one or more reports on its work, and forwarded them to the appropriate committee in London. Bulletins were published by the London organization throughout the year preceding the Congress reporting on the progress and attitudes being developed by these many study groups.

At the Congress itself, expert groups were set up to study and report to the Congress on the Report of the International Preparatory Commission. It is expected that more than three hundred study groups in many countries will continue their work, using the reports of the International Preparatory Commission and of the International Congress on Mental Health as a basis for further study. It is also expected that many additional study groups will be formed. At the final meeting of the Congress, it was announced that a World Federation for Mental Health had been constituted.

The full report of the Congress will not be in print until early 1949 but the recommendations addressed to WHO by the International Preparatory Commission were considered at the second session of the Executive Board of WHO. The Board endorsed those recommendations in general but made some practical reservations.²

The text of these recommendations is given below.

Recommendations to WHO

- 1 The successful administration of any public health programme involves the acceptance of the programme by the people on whose behalf it is administered and hence must take into account the attitudes varying in different cultures which may assist or obstruct the application of scientific knowledge. This is a point at which mental health principles can find direct and useful application.

Accordingly it is recommended that adequate attention be given to mental health principles in connexion with the undertakings of the World Health Organization in the control of maternal and child welfare, venereal diseases, tuberculosis and malaria, all of which have mental implications in respect to causative factors, effects and control.

- 2 That long term plans for comparative studies in the field of mental health be envisaged and steps taken immediately to facilitate such studies as

(a) determining the criteria by which mental ill health might be assessed by a nation or region.

² The second session of the Executive Board will be reported in the next number of the *Chronicle*.

- (b) securing and maintaining agreement on terminology nomenclature methods of survey statistical procedures
- (c) recognizing factors which are general to all countries and those which are specific to certain regions

In this connexion the World Federation for Mental Health and other international and national professional associations should be invited to furnish expert help where needed

- 3 That the World Health Organization call on appropriate international professional organizations (e.g. World Federation for Mental Health) for co-operation in the formulation and promulgation of principles important in promoting the healthy development of children
- 4
 - (a) That pilot studies and demonstrations in mental health education be undertaken
 - (b) That provisions be made for the widespread dissemination of mental health information including the results of research and demonstrations
 - (c) That there be international and interdisciplinary co-ordination in research effort
- 5 That international congresses in all fields of health be facilitated with representation from the various professions
- 6 That as soon as practicable an advisory expert committee be established composed of professional personnel in the field of mental health and human relations
- 7 That in co-operation with professional associations in various countries further international surveys of standards of professional training be undertaken along lines already carried out in relation to social workers with a view to the raising of these standards throughout the world such professional training being interpreted in the widest sense to include as many as possible of the professions regarded as responsible for mental health
- 8 That a definite minimum proportion of the total funds available for fellowships be devoted to fellowships for mental health personnel
- 9 That there be undertaken studies of the differences in approach to mental health education for each of the four groups
 - (a) persons working in professions related to health
 - (b) policy making bodies
 - (c) persons in the fields of radio press films etc
 - (d) the general public

NEW ASPECTS OF PLAGUE CONTROL

Meeting in Washington, D C, of a Group of Experts on Plague

At the request of WHO, a group of twenty experts¹ on plague, taking part in the Fourth International Congresses on Tropical Medicine and Malaria, met in Washington on 11 May. The group recorded its belief that, in view of the effectiveness of the new prophylactic and therapeutic measures as well as other methods of plague control, it is possible ultimately to eliminate plague as a human menace.

The opinion was generally expressed that, when intensive search for plague among rodents was carried out on a well planned and uniform scale many hitherto undisclosed enzootic zones would be discovered. Continuing surveys should therefore be undertaken to determine the enzootic and endemic plague areas throughout the world. Continued study of the life habits and other aspects of the ecology of animal hosts was also deemed necessary, as well as research on the geographical distribution and on the vector efficiency of local varieties of fleas.

Another important point that emerged from the discussions was the fact that, except in the case of pneumonic plague, quarantine and isolation measures are of little importance now that such a high degree of protection through the use of insecticides with residual action has been found possible. There is reason to hope, therefore, that thanks to DDT it may be possible to relax quarantine measures before long. However, even though plague control may no longer necessitate sanitary barriers, an early diagnosis of plague is nevertheless essential since therapeutic agents are more effective if applied in the early stages of the disease.

The group recommended that WHO should undertake or stimulate a comparative study between live and killed vaccines, fresh or preserved in field trials and research as well as a further study

Dr T B Turner Baltimore Dr W Bonne WHO Dr J S I Boyd London Dr I A Buxton London Dr C K Chu New York Mr D H S Davis Union of South Africa Dr D I Davis Baltimore Mr H Cielinski New York City Dr C Girard Paris Dr J I Corliss Boston Dr H C Hou Nanking Dr A M Macchiavelli Lima Dr K I Meyer San Francisco Dr C C Landit Madras Dr M Feltz Dakar Dr J M Ruegger Pearl River NY Dr H I Shortt London Mr J Gen Sir Sahil Singh Schrey Bombay Dr G K Strode New York Dr W C Workman Bethesda MD

of the value of drugs in preventing plague among individuals exposed to infection. Finally, the opinion was expressed that, since strains of *Pasteurella pestis* differ in their suitability for use in vaccine the importance of the free exchange among recognized laboratories throughout the world of the most effective strains should be emphasized. Continued study of methods of preserving the antigenic potency of strains is deemed desirable.

These recommendations were submitted to the first Health Assembly, which decided to set up an Expert Committee on Plague to study the most effective action for the elimination of plague. Last April, a joint OIHP/WHO study group met in Paris to consider the question.² Early in October it met again in Paris. Its findings will be reported in a subsequent issue of the *Chronicle*.

² *Chronicle WHO* 1948 - 144

FIRST WHO SOUTH EAST ASIA REGIONAL CONFERENCE

The first WHO regional conference which met in New Delhi to establish a health programme for South East Asia and to lay the foundations of a regional organization in that part of the world ended during the first week of October.

The conference was attended by representatives of the following States: Afghanistan, Burma, Ceylon, India and Siam, as had been decided at the first World Health Assembly,¹ which during its session in Geneva last summer defined the regions of the world in which regional organizations of WHO should be established. Observers from French India and Nepal also attended.*

The five countries which will form the regional committee for South East Asia decided during their meeting to recommend that the headquarters of the regional organization should be established at New Delhi and that the Executive Board should authorize the coming into being of that organization on 1 January 1949.

¹ *Chronicle WHO* 1948 2 191

* The following delegates and observers took part in the work of the Conference: Afghanistan: Sardar Ghulam Mohammed Khan; Burma: Dr U Ba Maung; Ceylon: Mr S. W. R. D. Bandaranaike; Dr S. F. Chellappah; Mr L. W. Kannanagare; Dr W. C. Wickremesinghe; French India: Dr Bigot; India: Rajkumari Amrit Kaur; Dr C. Mann; Dr K. C. K. E. Raja; Nepal: Colonel Bauang Jung; Thapa; Siam: Dr Luang Bhiyung Vejjasatri.

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London Dr P A Buxton London Dr C K Chu New York Mr D H S Davis
Union of South Africa Dr D F Davis Baltimore Mr H Cichini New York
City Dr C Girard Paris Dr J I Corliss Boston Dr H C Hou Nanking
Dr A M Marchiselli Lima Dr K I Meyer San Francisco Dr C C Lundin
Madras Dr M Lettler Dakar Dr J M Rueggsegger Pearl River N.Y. Dr H J
Slavitt London Maj Gen Sir Sibal Singh Bombay Dr G K Strode
New York Dr W C Workman Bethesda Md

NEWS FROM THE FIELD

China

Report from Hopei

Dr L. Eloesser and Miss Puth Ingram, a surgeon and a nurse in WHO's China Mission, have returned from a visit of over four months to the Communist-controlled area in northern China. Some extracts from their report are given below.

The International Peace Hospital, some 15 miles away from Han Tan, is in an ancient mountain village "high in a secluded valley at the base of a rocky range of hills composed partly of shale, partly of loess, and terraced to their very tops with small fields of millet, corn, wheat and cotton. This terracing is simple and effective: for the spring freshets, tearing loose sand and dust down the hill sides, soon fill the empty terraces with silted soil. The inhabitants are wild mountain folk, anxious to be helpful even though they may not always be entirely successful at it, and they are most appreciative of our coming. The houses are of mud (adobe) brick and stone. The rooms each contain a wide raised brick kang or bed, under which a fire may be made if there is coal to make one with. The villages are reached by bridle paths, inaccessible to carts, travelling largely in dry creek beds, and none too good for animals owing to the slippery shale with which they are paved.

"Being so difficult of access, the hospital (200 beds) contains mainly chronic sick: osteomyelitis, cardiacs, hernias, etc. None but the fairly robust could reach it, even in a litter."

Though short of a great many essentials, it is extremely well run—for example, "nursery visitors are gowned and masked." Since its inaccessibility has to some extent defeated its usefulness, it will be moved nearer to larger centres.

Here Dr. Eloesser and Miss Ingram taught the students and nurses from the medical college, some distance away, for three months. "There are 16 internes and residents, locally trained; 2 recently graduated 30% men. There are 10 locally trained students come over from Pei Ta for clinical training. There are 3 students from Shanghai Medical College, arrived a few days ago. There are but 2 qualified nurses, about a dozen undergraduate nurses and over 100 student aid nurses, the latter fresh from the plough. Eighty per cent of the nursing students are men. They are divided into three categories: (a) Qualified, (b) Qualifying, and (c) Preparatory. Some of the most promising will go to medical college after 1-2 years' practice. There are 4 midwives (one a man) and training in midwifery for student nurses to be included in their curriculum has begun."

Dr. Floesser also operated, and he produced an elementary illustrated surgical manual which was translated into Chinese. "None of my hearers

The delegates also considered ways and means of carrying out the six major health programmes established by the World Health Assembly, and recommended the allocation of an initial budget of \$600,000 for the purpose.

The regional committee for South East Asia in the course of its first meeting recommended that this sum should be devoted mainly to the financing of a field programme in the form of visiting experts, the purchase of medical supplies to combat tuberculosis and malaria, the award of fellowships to doctors and public health officials enabling them to specialize abroad in methods for improving nutrition, maternal and child welfare and for control of venereal disease, tuberculosis and malaria. The delegate of Ceylon also requested the support of WHO in the campaign against filariasis.

Rajkumari Amrit Kaur, Minister of Health of India, was nominated Chairman of the Regional Committee for South East Asia for the first year. Dr Chandra Mani, Deputy Director General of Health Services for India, was unanimously nominated Director of the Regional Office, which nomination was confirmed by the Executive Board of WHO. The Executive Board has agreed to the establishment of this regional organization about 1 January 1949. Once the regional office is established, it will act as the administrative body of the regional committee under the authority of the Director General of the World Health Organization.

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have the slightest theoretical foundation none of them have done an anatomical dissection nor witnessed a physiological experiment. The course therefore has to be simple, elementary and almost entirely practical. I have demonstrated wound treatment and débridement on a small kid secured with some difficulty (chest injuries and the effects of pneumothorax on a chicken) and have had the students practise bowel suture and the repair of bowel injuries on pig's intestine. Considering local conditions and welfare I have thought that the proper treatment of fractures and other injuries was probably the most important phase of surgical activity while the surgical treatment of non-incapacitating disease such as hernia or of largely incurable disease such as cancer was a luxury more or less unattainable in the present state of development of the region. I have therefore spent more time and attention on fractures and wounds than on the subjects discussed more explicitly in Western medical schools and have tried to familiarize the hospital personnel with their treatment. We have had drills and the students have reduced imaginary fractures and applied casts first on each other later putting their training to practice in the outpatient department and the wards. It has been a pleasure to see with what eagerness they have attended me: twenty students grouped about a table in the open courtyard of a Chinese mountaineers' home diligently sewing up pig's bowels with a needle and silk bought at the village market or hanging each other up in improvised fracture apparatus suspended from the roof beams of the gateway would make a refreshing movie for the American College of Surgeons.

Besides all this Dr Floesser tried his hand at producing smallpox vaccine, had a still made from a paper model to obtain pyrogen free water for intravenous injections and attempted the manufacture of peg legs.

A most interesting critical analysis of the statistical report on the conditions for which cases were admitted to hospital is appended with an analysis of the plans for medical and nursing education in the region. The party travelled back to Tientsin by wood burning truck, mule cart and train.

Canton Tuberculosis Centre

The small building in Canton, China, where every day adults and children wait patiently to be examined for tuberculosis constitutes only one aspect of the field work of the WHO mission in China but is a typical example of the demonstration activities which are being carried out in many countries.

Inaugurated late in June, the Canton Tuberculosis Centre is the fifth such centre to be established in China under the technical advice of WHO. It gives free x-ray examination and tuberculin testing and provides treatment with a charge applied only if the patients are able to pay. The treatment includes rest plus added measures of lung collapse and surgery when needed.

Dr I. M. Lourie, WHO expert, is in charge of the clinic. During the first month of operation he and his staff of specially trained Chinese tech-

nicians gave free diagnoses to 2 000 persons. In another month the Centre's diagnosis unit should be examining more than 1 000 persons a week.

The equipment for tuberculosis diagnosis includes two mass radiography units: one contributed by UNRRA and the other by the American Red Cross. It is expected that the Centre will begin BCG vaccinations early next year as is already done in similar clinics in Nanking, Shanghai, Peiping and Tientsin.

Set up as a part of a nation-wide programme carried out by Chinese health authorities with the assistance of WHO, the Canton Tuberculosis Centre serves a twofold purpose: detection of tuberculosis through radiological examinations and training of health personnel in the use of radiography apparatus as well as the interpretation of microfilms. It is expected that when the programme is completed there will be 19 such centres at strategic locations throughout China.

India

BCG Vaccination Campaign

The first nation-wide BCG vaccination campaign in India was officially inaugurated on 11 August at Madanapalle by Pajkumari Amrit Kaur, Minister of Health and a delegate to the first World Health Assembly.

This large-scale anti-tuberculosis programme is being carried out jointly by Indian health authorities and WHO, which sent a medical team of tuberculosis experts to India early last May. Since transportation of safe viable vaccine out of Europe into India cannot be guaranteed, a laboratory has been set up in India with the help of a WHO bacteriologist and is producing BCG vaccine.

It is hoped that this campaign will help reduce the high tuberculosis rate in India. The number of open cases is believed to be about two and a half millions out of a population of 320 millions. The annual mortality amounts to over 500 000. The incidence of the disease is of course higher in cities where it is estimated to vary from 7 to 10% in industrial centres.

Ceylon

BCG Vaccination

Prevention of tuberculosis through mass BCC vaccination recently begun in India has now extended to the Dominion of Ceylon under the auspices of WHO. The Ceylon Government has decided to open an extensive anti-tuberculosis campaign this November with inoculation of school children and university students in Colombo. The programme will be extended as rapidly as possible to other urban centres and later to rural areas by small teams trained in administering the vaccine.

The Ceylon Government is receiving advice and technical assistance from two WHO specialists. Dr Gellner and Dr Lind, sent to India last spring to organize the BCG campaign there and to begin production of the vaccine on a large scale. It is expected that adequate supplies of vaccine for Ceylon will be available from the King Institute of Preventive Medicine.

Madras produced with equipment purchased from Denmark with the advice of WHO

Haiti

The WHO has appointed Dr A Kundi, from The Hague as Medical Officer to the UNFSCO Basic Education Project in Haiti. He is expected to arrive there about 14 October. He has had long experience of tropical and semi tropical diseases in the Netherlands East Indies.

Ethiopia

Early in October General F Daubenton M.D. replaced Dr D A Messinezy as Chief of the WHO Mission in Ethiopia. General Daubenton recently retired from the post of Director General of the Netherlands Army Medical Services. He has had public health and administrative experience in South Africa the East Indies the Netherlands Great Britain and the United States.

Dr D A Messinezy is being transferred to Geneva after service of two years and eight months in Ethiopia.

Turkey

Dr J Vine Chief of the WHO Mission in Athens paid a brief visit to Ankara in June. At the request of the Turkish Government he has returned to Turkey for a further visit of about three weeks.

Greece

Dr D Thomson WHO Tuberculosis Officer in Greece was transferred to Copenhagen early in October. He will assist Professor Holm with the BCG vaccination programmes of UNICEF and the Scandinavian Red Cross Societies. He has been replaced temporarily in Greece by Dr N Frenkiel from Geneva.

Poland

The WHO Mission in Warsaw closed on 1 October. Dr D Borensztajn of the Polish Ministry of Health will act in future as Liaison Officer with WHO for the Fellowship and other programmes.

Visiting Lecturers

Included in the Visiting Lecturer Programme for October and November were visits by Professor Donald Hunter of London who lectured in Vienna on industrial diseases. He has previously visited Hungary to lecture on the same subject. Professor J M Mackintosh Dean of the London School of Hygiene and Tropical Medicine will be going to Finland. Dr C O S Birch Brooke Medical Officer of Health for Epsbury England to Italy where he will lecture on the new State Health Service in Great Britain. Professor H Ohlvecrona of Stockholm has recently lectured on "The Laryngeal Meningioma" in Budapest and Delreco and Professor Mackintosh on "Post War Housing Problems" in Budapest.

WHO PUBLICATIONS

Epidemiological and Vital Statistics Report

Vol I No 10 (March 1948)

Diversity of definitions of stillbirth and some statistical repercussions

It is known that the heterogeneity of definitions of stillbirth in different countries and the consequent lack of international comparability of its data have long been a matter of concern to demographers and statisticians. *Stillbirth figures affect several of the most important demographic indices* and unless corrections are made which take into account the peculiarities of the definition the picture of the real natality and mortality may be distorted.

This important matter was taken up by a special Commission of Expert Statisticians of the Health Organization of the League of Nations as a result of which a definition of stillbirth was in 1925 drafted and proposed. This definition was later studied and analysed by several governmental organizations by the American Public Health Association the Canadian Public Health Association etc. but not much progress in the unification of definitions on a wide geographical scale has been made in the last 20 years.

The difficulties due to the absence of uniformity in the definition of stillbirth will not be finally eliminated until an international definition is adopted. Yet the fact that vital statistics have a legal basis should not be overlooked: they reflect essentially the particular civil and juridical characteristics of the different countries. Moreover these aspects of laws and traditions are not easily changed as they also have important repercussions in other fields than vital statistics. No uniformization is therefore anticipated in the near future and this is why Dr Pascua a member of the Secretariat of WHO felt it necessary to attempt—pending a radical solution at a much later date—to bring some order in this field by preparing a study showing the great variety of definitions of stillbirth adopted in various parts of the world.

The tables and calculations set out in this study show that while we must wait for a modification of the legal definition of stillbirth after which the necessary improvements can be made by purely legal means a proper tabular classification and presentation of stillbirth statistics would be very useful to all those engaged in public health work.

The adoption of statistical methods of this kind will enable public health officials and others interested in the analysis of vital statistics to make the necessary numerical changes which will permit them to establish demographic rates the significance of which will be much more closely

related to biological reality than is now the case and the comparability of which will be made possible.

Tables on tuberculosis mortality in various countries complete No 10

Vol I No 11 (April 1948)

This number contains statistical tables on diphtheria scarlet fever measles and whooping cough mortality and morbidity

Vol I No 12 (May 1948)

This number contains statistical tables covering syphilis and gonorrhoea mortality and morbidity as well as an explanatory note concerning recent official figures for the disease

Vol I No 13 (June 1948)

This number contains an article by Dr J. Fabre a member of the Secretariat of the Interim Commission on the prevalence of smallpox during and after the second World War. A summary of this article will appear in the next number of the *Chronicle*. The number also contains statistical tables on morbidity and mortality from smallpox cholera yellow fever plague typhus and relapsing fever

Vol I No 14 (July 1948)

This number contains statistical tables on dysentery typhoid and paratyphoid fever mortality and morbidity

Weekly Epidemiological Record

3rd Year No 41 (13 October 1948)

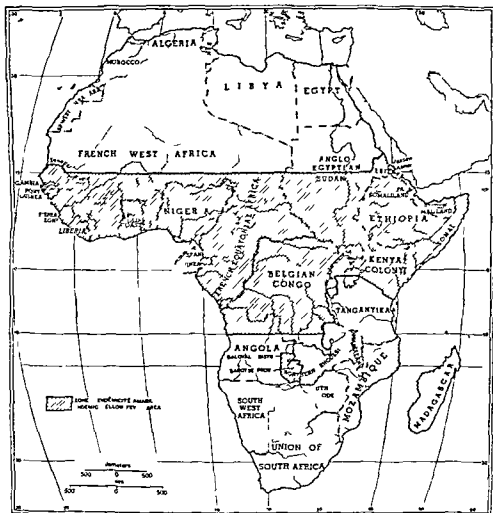
Endemic Yellow fever Areas

Under Article 36 (3) of the International Sanitary Convention for Aerial Navigation 1944 modifying the International Sanitary Convention for Aerial Navigation of 1st April 1933 the Contracting Parties agreed that for purposes of quarantine control UNRPA in consultation with the governments concerned and as regards the Western Hemisphere with the Pan American Sanitary Bureau shall define the boundaries of endemic yellow fever areas.

In this connexion UNRPA in fulfilment of its obligation under the above Article 36 (3) delineated the boundaries of endemic yellow fever areas in Africa and South America as indicated in figs 2 and 3.

These delineations are now almost universally adhered to by Governments Parties to the International Sanitary Convention for Aerial Navigation 1944 the administration of which transferred from UNRPA to the Interim Commission of WHO on 1 December 1948 is now and has been since 1 September 1948 in the hands of WHO itself.

Fig 2



The African Endemic Yellow fever Area (UNPRA Delineation)

Certain governments however before signing that convention expressed reservations and did not find themselves in entire agreement with the zones as defined by UNPRA

In Africa the port of Massawa and an area 10 km in radius from round the centre of the town of Asmara in Eritrea are not excluded from the endemic zone by Egypt India and Pakistan The last two State in addition extend UNPRA's delineation to cover Tanganyika the Belgian Congo all Angola and all Northern Rhodesia

In South America Brazil Bolivia Peru Ecuador Colombia Venezuela British French and Dutch Guiana are all included in the endemic yellow fever area by the Governments of Egypt India and Pakistan

In the same number of the *Record* there is a detailed account of the geographical distribution of yellow fever

related to biological reality than is now the case and the comparability of which will be made possible.

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NOTES AND NEWS

Pan American Sanitary Organization Approves Integration with WHO

The Directing Council of the Pan American Sanitary Organization, meeting in Mexico City unanimously approved a draft agreement providing for the integration of PASO with the World Health Organization

Acceptance of this agreement which already has been approved for WHO at the first session of its Executive Board last July means that the Pan American Sanitary Organization will act as the WHO regional organization for the Western Hemisphere

The agreement will be signed by the Director of PASO as soon as fourteen States members of PASO have deposited their instruments of ratification of the WHO Constitution Argentina Brazil Chile the Dominican Republic El Salvador Haiti Mexico the United States of America and Venezuela are already Members of WHO

The States not yet belonging to WHO are Bolivia Colombia Costa Rica Cuba Ecuador Guatemala Honduras Nicaragua Panama Paraguay Peru and Uruguay These twelve States signed the WHO Constitution at the 1946 International Health Conference in New York but they have not yet completed the necessary legislative action on the question of formal ratification They are now expected to do so within the near future

International Certificates of Inoculation and Vaccination

Booklets of the above Certificates are issued by the World Health Organization

A brief statement on their successive adoption and issue by UNRRA and WHO follows

Annexed to the International Sanitary Conventions of 1944 are International Certificates of Inoculation and/or Vaccination against cholera smallpox typhus and yellow fever

Between 15 January 1945 and 30 November 1946 sets of these certificates in booklet form were issued by UNRRA then responsible for the administration of the 1944 Conventions to national health services and to shipping and airline corporations catering for international travel The booklets were of such a size as to be conveniently carried within the holder's passport and their possession proved of much benefit to travellers

On 1 December 1946 the date on which administration of the 1944 Conventions was transferred to the Interim Commission of WHO considerable stocks of the UNRRA booklet were taken over by the Commission's Secretariat and after suitable overprinting of UNRRA on the cover with

Fig 3



The South American Endemic Yellow fever Area (U \ RR 1 Delineation)

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WHO is distributed on request to health administrations and to organizations concerned with international travel

On exhaustion of the UNRRA stocks the Interim Commission approved reprinting of the booklet which still corresponds with that formerly issued by UNRRA except that the text of the certificates is bilingual and that their footnotes indicate where necessary an extension to WHO or its Interim Commission of the approval previously given only by UNRRA

The popularity of the WHO booklet is evidenced by the issue during the past nine months of over 100 000 at nominal cost

In connexion with the whole subject of International Certificates of Inoculation and Vaccination it has to be noted that no amendment to their present form may be made unless recommended by the WHO expert committee entrusted with the revision of the sanitary conventions (the Expert Committee on International Epidemiology and Quarantine) and such recommendation endorsed by the World Health Assembly

List of Inoculation and Vaccination Requirements

In a large number of countries the health authorities require the traveller arriving from abroad to present valid certificates of inoculation and/or vaccination at the seaport airport or land frontier of entry Certain national administrations have expressed a desire that WHO should establish and maintain a current list of the requirements of each country in inoculation and vaccination

The need for the establishment and maintenance of such a list has been recognized by WHO and a circular letter was sent by the Secretariat to all Member States asking them to provide a statement on the certificates required by travellers reaching their territory from specified countries together with an indication of the type and period of validity of their certification The Member States were also asked to notify by telegram all changes made after 1 October 1948 in the certification requirements in order that the list compiled by WHO may be appropriately amended kept continuously up to date and duly communicated to all national health authorities and companies handling international travel

Quarantine Requirements

Several national health administrations have recently expressed the desire that the World Health Organization should place at their disposal by means of its official publications information regarding the various countries basic quarantine regulations applicable to international traffic and the countries and port against which such regulations were actually in force

It is proposed that the above information as of 1 October 1948 be published in special supplements of the *Weekly Epidemiological Record* as soon as obtained and later complemented and brought up to date in that same periodical

Inquiry into Sanitary Conditions of Refugees in Palestine

The late Count Folke Bernadotte United Nations Mediator in Palestine asked WHO to designate an epidemiologist to study epidemiological conditions among refugees in Palestine and to propose to Sir Raphael Cilento Director of Disaster Relief in Palestine any emergency measures that might be indicated

Dr H Mooser Professor of Hygiene at the University of Zurich has been entrusted with this task. An internationally known expert Dr Mooser distinguished himself in typhus control work in Mexico and carried out a relief mission in Northern China under the auspices of the League of Nations. Last year he headed the Swiss Red Cross Mission in Egypt during the cholera epidemic.

The plight of the Palestine refugees whose number is estimated at over 300 000 is aggravated by their almost total lack of food water clothing drugs and shelter. Typhoid dysentery smallpox and possibly typhus are among the major epidemic threats facing them.

Recommendations have recently been submitted to the United Nations Assembly if accepted they will imply further action on the part of WHO.

WHO European Health Conference

A conference of government representatives from all war devastated countries in Europe has been called by WHO and took place on 15 and 16 November at the WHO Headquarters Geneva.

The purpose of the conference was to discuss the establishment of a special temporary administrative office to assist in the health rehabilitation of European countries devastated during the war. Delegates considered the nature and extent of the services desired by individual countries and decided on the size and location of the administrative office required for the task.

First Contribution to WHO 1948 Budget

The first contribution from a State Member has been recently received from the Government of the United Kingdom.

The British Government has deposited its full contribution for 1948 amounting to 535 679 US dollars.

The WHO budget for the period ending 31 December 1948 totals 4 800 000 US dollars. This includes repayment of a loan made by the United Nations to the WHO Interim Commission amounting to 2 150 000 US dollars.

The contribution of the United Kingdom based on a unit system adopted last July at the first Health Assembly amounts to 1 378 out of a total of 12 612 units.

Appointment of two WHO Representatives to the Drug Supervisory Body

Dr Hans Fischer Professor of Pharmacology at the University of Zurich Switzerland and Dr Sedat Tavakoli Professor of Pharmacology and

Therapeutics at the Faculty of Medicine University of Istanbul Turkey have been appointed by WHO to membership of the Drug Supervisory Body

The Drug Supervisory Body is expected to meet twice yearly to implement the decisions of the Convention to limit the manufacture of narcotics The WHO is co operating in this question with the Permanent Central Opium Board of the United Nations

Recent and Forthcoming Meetings

22 23 October	Working Party of the Standing Committee on Administration and Finance of the Executive Board on allocation of residual UNRRA funds Geneva
25 October	Executive Board second session Geneva
11 12 November	Joint UNICEF WHO Committee Paris
15 16 November	Conference of representatives of war devastated countries for the establishment of a temporary administrative office for Europe Geneva
15 20 November	Expert Committee on International Epidemiology and Quarantine Geneva
January (tentative)	Expert Committee on Maternal and Child Health Geneva
March April (tentative)	Subcommittee on Liposoluble Vitamins London
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CORRIGENDA

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CHRONICLE OF THE WORLD HEALTH ORGANIZATION

VOL. II No 11

November 1948

PLAN FOR THE CONTROL OF TUBERCULOSIS IN UNDER-DEVELOPED COUNTRIES

Third Session of the Expert Committee on Tuberculosis

During its third session, held in Paris 15-19 October 1948,¹ the Expert Committee on Tuberculosis - drew up a suggested plan for tuberculosis control intended for those countries which, up to now, have little or no existing programme.

Tuberculosis, as has been frequently pointed out in previous issues of the *Chronicle*, constitutes one of the main preoccupations of WHO. The ravages of the disease in most countries which have been theatres of war have reached alarming proportions, and it is for this reason that WHO has devoted so much effort during the last two years to the control of tuberculosis. WHO has assumed the scientific responsibility for a BCG vaccination campaign of a magnitude hitherto unknown, in which 50 million children will be examined and probably 15 million vaccinated in many European countries.² BCG campaigns have recently been inaugurated in

¹ The report on the third session will be published in *Off Rec WHO* 15

² The following members were present

Dr P M d Arey Hart Farm Laboratories National Institute for Medical Research (Medical Research Council) London United Kingdom

Dr H E Hilleboe Commissioner of Health New York State Department of Health Albany NY USA

Dr J Holm Chief Tuberculosis Division State Serum Institute Copenhagen Denmark (Chairman)

Secretary: Dr J B McDougall member of the Secretariat of WHO

³ *Chronicle WHO* 1948 - 34

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Technical Organization

A technical organization should be set up as the result of the survey and should be composed as follows

Central group

This group would comprise representatives of public health administration, epidemiology, laboratory and clinical subjects, and public health nursing. One person of the group could cover more than one subject. The group should be directed by a person experienced in public health administration, possibly a specialist from outside, but on a temporary basis only.

It might not be possible to obtain all the personnel of the group at the beginning of the programme. In many countries the greatest assistance that WHO could render in tuberculosis control would be to train personnel as a group in special centres. When the central group returns to its own country, it must assume responsibility for the training of new personnel.

The organization will carry on its work on three different planes

Central laboratory

This laboratory, which may be supplemented later by subsidiary decentralized laboratories, should be concerned with exact diagnosis of tuberculosis according to the latest scientific methods. It should preferably work in association with a general bacteriological laboratory.

Records

It would be advisable to establish a record and filing system so that the centre would have the documents containing all data on diagnosed cases. These records could form the nucleus for a more comprehensive system throughout the country, in the event of tuberculosis notification becoming compulsory.

Medical care (at home and in hospitals)

These measures, the purpose of which is to avoid or to limit the spread of tuberculosis, would vary according to the possibilities in each country.

¶ *Home nursing services* Home care, which ensures only partial isolation of infectious cases, must be considered as a temporary

India and Ceylon under the auspices of the Organization, which has sent experts to advise on the production and application of BCG ⁴

The health missions of WHO in Austria, China, Ethiopia, Greece, Italy and Poland have been contributing in many ways to the control of tuberculosis ⁵ The contribution of WHO in the purely scientific field, if less spectacular, has been none the less important, and has included consideration of the standardization of BCG and tuberculin and the formulation of principles governing streptomycin therapy ⁶

It is clear however, that WHO alone cannot hope to obtain decisive results in the fight against tuberculosis It is the national health administrations which must undertake measures to reduce tuberculosis mortality and morbidity rates To assist the health authorities of those countries which have as yet no anti tuberculosis programme the Expert Committee on Tuberculosis has taken the initiative of drawing up a general plan which can be varied according to the countries concerned, so that it can respond to the needs, the resources and the psychological attitude of the peoples

According to the expert committee, in a country with limited means a logical anti tuberculosis programme should aim, not at the treatment of advanced cases but at preventing the spread of the disease by the treatment of known infectious cases and the protection of highly exposed groups To accomplish these objects various administrative and technical measures must be taken, the broad outline of which has been suggested by the committee

Anti Tuberculosis Survey

A survey possibly by a tuberculosis specialist provided by WHO, should be made on existing information on tuberculosis morbidity rates in the country, or information should be collected by means of rapid examinations of certain population groups It would also be important to ascertain the psychological attitude of the people and to make contact with those groups that are already interested in tuberculosis control or are likely to become so

⁴ *Chronicle WHO* 1948 2 - 9

⁵ *Ibid* 1947 1 184 1948 2 120

⁶ *Ibid* 1947 1 107 1948 2 117 215

Technical Organization

A technical organization should be set up as the result of the survey and should be composed as follows

Central group

This group would comprise representatives of public health administration, epidemiology, laboratory and clinical subjects, and public health nursing. One person of the group could cover more than one subject. The group should be directed by a person experienced in public health administration, possibly a specialist from outside, but on a temporary basis only.

It might not be possible to obtain all the personnel of the group at the beginning of the programme. In many countries the greatest assistance that WHO could render in tuberculosis control would be to train personnel as a group in special centres. When the central group returns to its own country, it must assume responsibility for the training of new personnel.

The organization will carry on its work on three different planes

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⁴ *Chronicle WHO* 1948 2 209

⁵ *Ibid* 1947 1 184 1948 - 1 0

⁶ *Ibid* 1947 1 10 1948 2 117 215

population can be examined within a definite period of time. At the same time, if large numbers of persons requiring sputum examination to confirm or exclude the diagnosis of infectious tuberculosis are already known to physicians in the country, there is no point in detecting an additional number of suspected cases by mass radiography, until laboratory examinations and exact diagnoses have been made in the first mentioned group.

UNIFICATION OF PHARMACOPŒIAS

The Expert Committee on the Unification of Pharmacopœias held its second session from 31 May to 5 June 1948, and its third session from 15 to 23 October 1948, in Geneva.¹

During these two sessions, the chief work before the committee was the examination of a large number of monographs to be included in the international pharmacopœia, publication of which is expected during 1949. Preparation for this work, which had been started by the Technical Commission of Pharmacopœial Experts of the League of Nations and had been interrupted by the war, has continued under the auspices of WHO. It will be recalled that, at its first session, the committee had divided drugs into three categories: category A, comprising those drugs extensively used in modern therapeutics; category B, drugs of secondary importance; and category C, comprising drugs not considered worthy of inclusion.²

¹ The following members were present:

Professor H. Biggesgaard Rasmussen, Chairman, Chemical Division of the Danish Pharmacopœia Commission, Copenhagen, Denmark.

I. Fullerton Cool, M.Sc., Chairman, Committee of Revision of the Pharmacopœia of the United States of America, Philadelphia, Pa., USA.

I. R. Lahmy, Ph.D., Professor of Pharmacognosy, Foudi University, Cairo, Egypt; Secretary of the Egyptian Pharmacopœia Commission.

H. Flück, Dr. Sc., Nit, Professor of Pharmacognosy, Eidgenössische Technische Hochschule, Zurich, Switzerland; member of the Swiss Federal Pharmacopœia Commission.

Dr. C. H. Hampshire, Secretary of the British Pharmacopœia Commission, General Medical Council Office, London, United Kingdom (Chairman).

Dr. R. Hazard, Professeur de Pharmacologie et de Matière médicale à la Faculté de Médecine de l'Université de Paris, France (prevented by illness from attending the second session; took part in the third).

Professor D. van Os, Professor of Pharmaceutical Chemistry and Toxicology, University of Groningen, Netherlands; President of the Netherlands Pharmacopœia Commission.

² The report on the second session of the expert committee will be published in *Off. Rec. WHO* 11; that on the third session in *Off. Rec. WHO* 15.

³ *Chronicle WHO* 1947, 1: 149.

measure to be used only when the number of hospitals is found to be inadequate. WHO could be of great assistance in helping to train personnel devoted to this work.

Hospital facilities Hospital facilities should be the object of a special study. Hospitalization and the treatment of recognized cases should be as simple as possible. The number of beds needed and the time schedule for obtaining them would be determined according to the conditions in each country. Dispensaries, separate from but working closely with hospitals, should be established in communities where their usefulness is obvious.

As far as the budget and the allocation of funds are concerned, the committee believed that the object should be to obtain the largest possible number of hospital beds for the isolation of patients and to ensure the extension of proper treatment to arrest the disease. Thus it would seem unwise to spend available funds on the construction and maintenance of the most modern type of sanatoria, fully equipped with every facility for surgical and other treatment. Such costly institutions would accommodate only a small number of patients. Similarly, in countries with limited resources, little could be accomplished by spending large sums on a model tuberculosis control programme in a small selected area as this would have little effect on the tuberculosis control problem of the country as a whole.

Vaccination

Finally, a large scale BCG vaccination programme should form one of the elements of the anti tuberculosis campaign, it being always understood however that vaccination by itself cannot be expected to control the disease.

Mass radiography

The committee was firmly convinced that mass radiography should not be undertaken in countries with little or no facilities for exact diagnosis or for the supervision of persons (laboratory services, dispensaries and hospital care). In other words, there would seem little value in radiography of the lungs of millions of people if no subsequent measures were taken. Mass radiography is effective as a control procedure only in countries with highly developed tuberculosis control programmes where large groups of the

international standards for them. Only old tuberculin has been retained, as a satisfactory standard already exists.

Relationship with other expert committees

The study of certain groups of monographs requires consultation with other expert committees, monographs concerning habit forming drugs, for example, being sent to the Expert Committee on Habit forming Drugs for its opinion.

The final presentation of monographs on vaccines, antitoxic sera, hormones and vitamins will depend on decisions taken by the Expert Committee on Biological Standardization, the opinion of which will also be invited with a view to establishing potency tests for arsphenamines and antitoxic sera. For the definition of vitamin A and D units (which appear in the monographs on fish liver oils), the decision of the Subcommittee on Liposoluble Vitamins, set up by the Expert Committee on Biological Standardization, will be awaited.

The committee agreed to inform the Expert Committee on Malaria of the decision taken on quinine sulphate, the standard of purity of which has been so fixed that the product will remain cheap enough for widespread use in any antimalarial campaign. It was agreed, moreover, that the Expert Committee on Malaria should suggest essential antimalarial drugs for inclusion in the pharmacopœia.

After having allocated the share of each member in the preparation of monographs, revision of certain data and the comparative study of various methods and tests, the committee suggested that its fourth session should be held at the end of April 1949.

During its last two sessions, the committee examined 162 draft monographs of drugs in category A

During the examination of the individual monographs, many questions of general interest came up for discussion relating to methods of analysis and to the various tests and assays, the description of which is to appear in the general notices of, or in appendices to, the pharmacopœia. Improved production methods and the ever increasing purity of chemical substances make necessary the constant revision of much data.

As a uniform method is essential for the attainment of uniform results, methods of determining melting and boiling ranges were discussed and approved during the third session. All the melting and boiling ranges published in the pharmacopœia will be arrived at in accordance with techniques adopted by the committee.

Biological tests, and tests of the activity and toxicity of potent drugs and of arsenicals and antitoxic sera were discussed at length. Tests will be suggested in appendices to the monographs, but they will not be obligatory as in most countries official regulations require tests for which those of the pharmacopœias cannot be substituted.

A table of usual and maximum doses for drugs in common use was drawn up and will be submitted to the members of the committee, who will refer it to physicians in their respective countries for comment.

With regard to nomenclature, the Latin name of the drug will be followed by the chemical name of the substance, its usual formula, and its structural formula wherever useful. Synonyms will be used, but not as a general rule.

A problem in nomenclature arose during the examination of monographs on antitoxins. Ambiguity may arise from the fact that the French word *antitoxines* which in the draft monographs was used for antitoxic sera, refers only to antitoxins in a pure state and not to the antitoxic sera. Thus, to avoid any confusion, it was decided that the Latin term *sera antitoxica* should replace *antitoxina*. Each serum will take its name from the bacterial toxin which it acts upon, e. g. *serum antidiphthericum*, *antitetanicum*, etc.

Vaccines will be omitted from the draft pharmacopœia, in view of the impossibility at the present time of establishing satisfactory

Dr Mani (India) in his statement said that the members of the regional committee had been particularly conscious of the fact that they had embarked on the first regional effort of WHO. The significance of the event was also emphasized by the Chairman, who observed that the steps that had made it possible might well serve as a pattern for other regional organizations.

In approving the establishment of the office, which will come into being on or about 1 January 1949, the Board unanimously appointed Dr Mani its Director, thereby endorsing the nomination of the regional committee. He was warmly congratulated by the Chairman and other colleagues, who spoke in high terms of his services as a member of the Interim Commission and the Executive Board.

The regional committee's choice of New Delhi as the site of the regional office was approved by the Board, subject to consultation with the United Nations.

Agreement with PASO

The second important regional development reported to the Board was the acceptance on 12 October, by the Directing Council of the Pan American Sanitary Organization, of the draft agreement between WHO and PASO.³

In presenting his report on the negotiations, Dr Zozaya emphasized that the agreement had been endorsed unanimously by the 19 countries members of PASO at the Mexico City meeting.

In the discussion on the subject, members of the Board expressed the view that this initial agreement, though an important step forward, would not constitute final and complete integration. It was nevertheless recognized that the agreement would enable the Pan American Sanitary Bureau to act as a regional organization and to receive funds from WHO for those of its activities undertaken on behalf of the Organization.

Administrative Office for Europe

The site of the proposed temporary special administrative office for health rehabilitation of war devastated countries in Europe was discussed but several members felt that it was still too early to take

³ *Chronicle WHO* 1948 - 235

SECOND SESSION OF THE EXECUTIVE BOARD

Geneva 25 October — 11 November

The main task before the Executive Board, at its second session recently held in Geneva, was to give specific application to the plans and policies formulated by the first World Health Assembly. At the same time the members had an opportunity of assessing the progress of the Organization since it assumed adult status on 1 September 1948.

After 18 days of debate on a wide range of topics, approval was given on 11 November to the draft report on the session, which listed the many important decisions reached—some directly concerned with the health programme, some with WHO's expanding structure, others dealing with its relationships with other bodies in allied fields.

The meetings under the chairmanship of Sir Aly Shousha, Pasha, were attended by sixteen of the eighteen members of the Board.¹ Observers represented the United Nations, FAO, ILO, IRO, the Interim Commission of the International Trade Organization, the Office International d'Hygiène Publique and UNESCO.

The first session of the Board, held in July at the close of the Health Assembly, had largely devoted itself to organizational matters; the agenda of the second session covered a much wider field, but special attention was paid on the organizational side, to the regional development of WHO.

South East Asia Regional Office

The Board noted with particular satisfaction two important steps towards implementation of the regional system contemplated by the Health Assembly. The first of these was the plan for the South East Asia Regional Office drawn up at New Delhi on 4 and 5 October.²

¹The following attended: Dr C. van den Berg (Netherlands), Dr D. A. Dowling (Australia), Dr K. Elvang (Norway), *Vice-Chairman*, Dr H. S. Gear (Union of South Africa), Dr M. H. Hafezi (Iran), Dr H. van Zile Hyde (United States of America), Dr B. Kozusznik (Iceland), Dr M. D. Mackenzie (United Kingdom), Dr C. Mani (India), Prof J. Laroche (France), Dr C. H. Le Paula Souza (Brazil), Sir Aly Shousha Pasha (Egypt), *Chairman*, Dr A. Stampar (Yugoslavia), Dr W. G. Wickremasinghe (Ceylon), Dr W. W. Yung (China), *Vice-Chairman*, Dr J. Zozaya (Mexico).

artificial immunization, preservation of records, general evaluation of the effect of the programme and of the possibility of obtaining better morbidity and mortality statistics

Bureau of Medical Supplies

A recommendation on the setting up of a bureau to give advice on the procurement of essential drugs, biological products and other medical supplies had been referred to the Board by the Health Assembly

To implement this recommendation, the Board approved the establishment, in the headquarters office of WHO, of a unit to provide a medical supply advisory service. Its chief function will be to furnish information and advice to governments, but in cases of emergency the unit may itself act as a procurement body

At the same time, the Board authorized the Director General to make preliminary studies on the possibility of encouraging production in countries possessing raw materials but unable to manufacture finished products

Mental Health

A report on the International Congress for Mental Health, held in London in August, was submitted by the Director General

The recommendations addressed to WHO⁴ were approved in principle, and the Director General was requested to consult with the World Federation for Mental Health on preliminary studies in connexion with long term plans for comparative studies in mental health

The Board felt that certain other studies and surveys in addition to those suggested by the International Preparatory Commission should be undertaken in co operation with other specialized agencies such as UNESCO, or with sections of the United Nations

Advisory and Demonstration Services and Fellowships

The Board authorized an appropriation of 800,000 dollars for advisory and demonstration services to governments and approved an allocation of 650 000 dollars for fellowships and medical literature

⁴ *Chronicle WHO* 1948 - 22.

a final decision. The Board decided that the Director General should establish an office at his discretion, after opinions had been expressed at the conference to be held on the subject immediately after the session.

Regional Administration

Of the 300,000 dollars provided for administrative purposes under the regional budget, the Board allocated 200,000 dollars for the administration in 1949 of those regional organizations to be established in the near future. The allocation of the remaining 100,000 dollars will be considered at a later session. Should additional regional organizations be established in 1949, the sum will be used for their development, otherwise it will be made available to those already in existence.

Tuberculosis Research Programme

Among the many absorbing topics to which members of the Board would obviously have liked to devote more time had their busy schedule permitted was the BCG vaccination campaign now being carried on in nine European countries by UNICEF and the Danish Red Cross and its Scandinavian associates, with technical assistance from WHO.

A research programme which might be undertaken in conjunction with the campaign was outlined by Dr J. Holm, director of the joint project and Dr C. Palmer, UNICEF tuberculosis research expert.

The Board accepted responsibility for the promotion of such research and earmarked for the purpose the sum of 100,000 dollars, part of a grant received from UNRRA.

Dr Palmer indicated six types of research which could be integrated into the general BCG programme:

- (a) investigation of the criteria for vaccination,
- (b) development testing and use of a preserved vaccine,
- (c) revaccination and the value of criteria in the selection of groups to be vaccinated,
- (d) collection of statistical material
- (e) research on the effectiveness of BCG, as one of the techniques in the control of tuberculosis,
- (f) miscellaneous studies, such as family and racial differences in susceptibility and resistance to tuberculosis, response to

the requests of governments. The committee specifically suggested that a temporary study group consisting of a limited number of outstanding venereologists from Europe and other regions, be established in 1949 to assess the value of national and international programmes of the venereal disease control methods in use in USA.

In the ensuing discussion some members felt that the reference to Europe in the recommendation was too restrictive. It was pointed out, however, that adherence to traditional methods of treating syphilis was mainly located in Europe, and that representatives from other regions would also be included in the study group.

Dr Hyde observed that the survey could also be of value to the United States, as it might serve to suggest improvements in the methods employed there.

The Director General felt that in presenting the suggestion the expert committee had courageously accepted a very difficult responsibility. A state of controversy existed as to technical procedures and practices in the treatment and control of syphilis, the centres of opposing thought being USA and Europe. He saw in the expert committee's recommendation an attempt to resolve those difficulties by bringing together the advocates of two viewpoints to enable them to thrash out their difficulties.

The Board's approval of the recommendation was supplemented by appropriate comment reflecting the opinions expressed.

The Board was interested to note from the report that in one country experiments had recently been carried out on a possible new method of penicillin production which aims at dispensing with the growth media usually employed, often difficult to obtain in sufficient quantities and utilizing instead a more readily available substance containing similar growth factors. The expert committee felt that, should this process stand the test of mass production it might form the basis for a wider production and accessibility of penicillin.

In approving the report as a whole the Board agreed that surveys should be made with a view to the rehabilitation of the UNRPA penicillin plants. It noted specifically the committee's commendation of the progress made in the Polish anti-syphilis campaign.

Other Matters

The Director General was requested to continue preliminary studies on the international aspects of such subjects as brucella, etc.,

So many requests for assistance had been received, however, that it was clear that they could not all be met by these sums. Twenty eight governments desired advisory and demonstration services, 30 had asked for fellowships, and from 21 had come requests for medical literature, supplies and equipment. The total list represented at a rough estimate, at least twice the amount available for advisory and demonstration services, and almost four times that earmarked for fellowships.

The Board therefore adopted a set of guiding principles which will be taken into consideration in the approval of the advisory and demonstration programmes.

The first criterion will be whether the services are in fact available under the WHO programme. Relevant decisions, plans or programmes of the United Nations or specialized agencies will also be taken into account as well as such considerations as the importance of the problem to the whole health programme of the requesting country, the ability of the country itself to provide the services, the probability of achieving successful and useful results, and relevant recommendations of an expert committee. On the part of the government there should be reasonable assurance both of satisfactory co-operation and where appropriate of continuance of the programme.

As the requests mount beyond the available budget, every effort will be made to ensure equitable distribution by progressively stricter application of the guiding principles.

A sum of 70,000 dollars which had not been specifically allocated by the Health Assembly will be utilized in accordance with these principles for the expansion of field services in malaria, tuberculosis, venereal diseases, maternal and child health and public health administration.

Venereal Disease Control

A useful exchange of views took place on certain aspects of the report on the second session of the Expert Committee on Venereal Infections which came before the Board for approval.

One of the expert committee's recommendations was that WHO should study ways and means of increasing the dissemination of technical information on venereal disease control methods, to meet

* A note on the report will appear in a forthcoming issue of the *Chronicle* — 10

Prophylaxis of Pneumonic Plague

As the different clinical forms of plague are due to the same causal organism, the group was of the opinion that quarantine measures against bubonic plague to be laid down in international sanitary legislation should apply equally to pneumonic plague. However, additional measures would be required in certain cases.

Thus, a focus of pneumonic plague with no tendency to spread or to form secondary foci does not require, apart from notification, any particular international action. On the other hand, when an epidemic area is formed — that is, when an increasing number of cases has given rise to distinct secondary foci — international prophylactic measures are indicated. Such measures should include, for contacts wishing to leave the zone, observation for a period of five days from the date of last exposure to infection.

The study group recommended the prophylactic treatment of contacts with sulfonamides or streptomycin. It also recommended that, when occasion arose, a study should be made of whether prophylactic treatment with these drugs is capable of shortening the period of observation of contacts.

Protective measures for cities, air- and seaports

The study group considered the following measures as appropriate for the protection of cities, air- and seaports:

- (a) rat proofing of buildings and out buildings
- (b) application of 5-10% DDT powder every six months or at intervals compatible with the maintenance of an absolute flea index under 5
- (c) deratization with sodium fluoracetate (1080) or another effective rodenticide after DDT spraying
- (d) protection of merchandise with 5-10% DDT powder
- (e) application of 5-10% DDT powder to vehicles in case of epizootic recrudescence within an enzootic area

For the protection of airports, it was recommended that special measures be taken, including the maintenance of a clean zone within a radius of 200 metres around the airport buildings and the ground used for the parking of aircraft, and the exclusion from this area of

rabics, dental hygiene and physical training. A number of the Board's decisions encouraged the development of technical liaison with other organizations. The draft Declaration of the Rights of the Child was studied and returned to the United Nations with certain modifications. Among the many other matters discussed were the BCG vaccination campaign in India, industrial hygiene and the hygiene of seafarers, the unification of pharmacopœias, relations with non governmental organizations, editorial matters and publications, and personnel and budgetary questions. Fuller reference will be made to some of these in the next issue of the *Chronicle*.

QUARANTINE MEASURES AGAINST PLAGUE

Second Session of the Joint OIHP/WHO Study Group on Plague and Typhus Paris

The Joint OIHP/WHO Study Group on Plague and Typhus held its second session in Paris from 5 to 8 October 1948¹. The study of possible changes in the quarantine measures against plague, begun during the first session was continued by the group.

The following members were present

- Dr L. J. Y. Aujaleu Directeur de l'Hygiène sociale Ministère de la Santé
publique et de la Population Paris France
- Dr G. Blanc Directeur de l'Institut Pasteur du Maroc Casablanca Maroc
- Dr I. C. C. Garnham Reader in Medical Parasitology London School of
Hygiene and Tropical Medicine London United Kingdom
- Dr V. Macchiavello US Public Health Service Consulting Epidemiologist
Pan American Sanitary Bureau Lima Peru
- Professeur A. R. Dujarric de la Rivière Sous Directeur de l'Institut Pasteur
Paris France and Médecin Général Inspecteur M. A. Vauzel Directeur
du Service de Santé coloniale Ministère de la France d'Outre Mer Paris
France also attended

Secretariat

- Dr M. Gaud Directeur de l'Office International d'Hygiène Publique Paris
who acted as chairman
- Dr Y. M. Biraud Director Division of Epidemiology WHO
- Dr W. M. Bonne Director Division of Planning WHO
- Dr M. M. Sidky Medical Officer Division of Epidemiology WHO
- Dr G. Stuart Chief Sanitary Conventions and Quarantine Section WHO

SMALLPOX

The Joint OIHP/WHO Study Group on Smallpox held its second session in Paris on 18-19 October 1948 ¹

The chief points for discussion were the nature of the virus, its contagiousness in the pre-eruptive stage, and vaccination

Viruses

The study group noted that no morphological difference had been detected between the smallpox and the vaccinia viruses when examined by the electron microscope. On the other hand, the morphological differences shown on macroscopic examination of cultures of these two viruses on the chorio-allantoic membranes of chick embryos three or four days after inoculation might be used for differentiation. The fact that the vaccinia but not the smallpox virus will propagate on rabbit skin could also be used as a method of differentiation.

The study group recommended that an investigation be made of possible morphological differences between the variola major and alastrim viruses by means of the electron microscope and other methods.

Contagiousness of Smallpox in the Pre-eruptive Stage

One member of the study group reported that during experiments, within 12 hours of its formation, a papule contained the virus, which

¹ The following members were present

Dr L. T. Conybeare, Medical Officer, Ministry of Health, London, United Kingdom

Prof. eur. A. Lemierre, Académie de Médecine, Paris, France

Dr R. F. Muckenfuss, Assistant Commissioner, New York City Health Department, New York, USA

Dr C. C. Panjit, Secretary, Indian Research Fund Association, New Delhi, India

Professeur A. R. Dujardin de la Rivière, Sous-Directeur de l'Institut Pasteur, Paris, France, and Dr A. Macchiavello, US Public Health Service Consultant Epidemiologist, Pan American Sanitary Bureau, Lima, Peru, also attended the meeting.

Secretariat

Dr M. Caud, Directeur de l'Office International d'Hygiène Publique, Paris, who acted as chairman

Dr Y. M. Biraud, Director, Division of Epidemiology, WHO

Dr C. Stuart, Chief, Sanitary Conventions and Quarantine Section, WHO

buildings which have not been rat proofed. In addition, the application of DDT to aircraft as well as to merchandise coming from enzootic zones and which in the judgement of the health authorities, might contain infected fleas was considered necessary.

In case of an epidemic in the enzootic zone, there should be systematic application of 5-10% DDT powder to the personal effects and garments of passengers coming from the infected zone.

Among the other questions considered by the group may be mentioned the determination of enzootic and endemic plague areas throughout the world, the definition of the term sylvatic plague, the relation between wild rodent plague and human plague, inter human transmission of bubonic plague anti plague vaccination, etc.

Control of Plague in South America

Before adjourning the study group was informed of the results obtained by one of its members Dr Macchiavello, in the control of plague in South America. The combined application of DDT and 1080 had suppressed both the epidemic and enzootic plague in villages and towns. In rural areas it suppressed the epidemic but, except in very circumscribed areas did not control the epizootic. In areas where wild rodent plague is prevalent the application of DDT alone would require in order to be effective so large a quantity of the insecticide as to render the method impracticable.

Field experiments had shown that in the control of plague DDT powder at 5% gave better results than DDT in solution. In an area where plague appeared seasonally, one application of DDT was sufficient to prevent its return provided it was made before the usual period of seasonal recrudescence. Among rodenticides, sodium fluoracetate (1080) was the most efficient.

The results of Dr Macchiavello's experiments will be communicated to physicians and to sanitary personnel in a special training centre to be organized under the joint auspices of the Peruvian Government and the Pan American Sanitary Bureau.

useful for verifying the effectiveness of new types of vaccinia or of new vaccination methods

Vaccination against Smallpox and Yellow Fever

The intervals which should elapse between the administration to the same individual of smallpox vaccine and of yellow fever vaccine were examined. It was agreed that yellow fever vaccine should be administered first and smallpox vaccine 15 days later, so as to reduce to a minimum the possibility of occurrence of post vaccinal encephalitis. Should, for unavoidable reasons, smallpox vaccine be administered first, an interval of 21 days should elapse before yellow fever vaccine is inoculated. This precaution did not seem to be necessary in Africa, where encephalitis is non-existent, and where some 17 million combined smallpox and yellow fever vaccinations have been performed without any encephalitic after-effects.

CHOLERA ENDEMICITY

The second session of the OIHP/WHO Study Group on Cholera, Paris, 13-15 October 1948,¹ was mainly concerned with the endemicity of cholera. This is an important aspect in the control of the disease, closely related not only to essential quarantine measures—the traditional method of defence—but to offensive action, as

¹ The following members were present

Sir M. Shousha Pasha Under Secretary of State Ministry of Public Health, Cairo Egypt Chairman Executive Board WHO

Dr C. G. Pandit Secretary Indian Research Fund Association New Delhi India

Dr I. Bruce White National Institute for Medical Research (Medical Research Council) Hampstead London United Kingdom

Professeur A. R. Dujarrie de la Riviere Sous-Directeur de l'Institut Pasteur Paris France Dr A. Macchiavello U.S. Public Health Service Consultant Epidemiologist Pan American Sanitary Bureau Lima Peru Dr O. Ouchterlony State Bacteriological Laboratory Stockholm Sweden and M. lecin Général Inspecteur M. A. Vauzel Directeur du Service de Santé colonial Ministère de la France d'Outre Mer Paris France also attended the meetings

Secretariat

Dr M. Gaud Directeur de l'Office International d'Hygiène Publique Paris France who acted as chairman

Dr Y. M. Biraud Director Division of Epidemiology WHO

Dr C. Stuart Chief Sanitary Conventions and Quarantine Section WHO

was easily obtained by a slight and invisible scratch of the lesion with a needle. This interesting observation, which was discussed by the study group, would suggest the possibility of the minor traumata, due to scratching or even to friction of clothing, causing liberation of the virus in the pre-vesicular stage.

The study group had discussed during its first session the problem of contagion beginning with patients in the pre-eruptive phase, as this is of great practical importance in the prophylaxis of smallpox.¹

Vaccination

The study group considered the opportunities offered by the French health authorities for extensive and intensive investigations to be made into the vaccinal and serological response of vaccinated and revaccinated infants, children and young adults.

The following suggestions were made for carrying out these investigations:

- (a) Study of the vaccinal response to annual re-vaccination up to 5 years of age of children primarily vaccinated within the first three months of life—care being exercised to have the vaccination and re-vaccinations made with the same technique and with vaccine of the same titre prepared by the same institute.
- (b) Study of the vaccinal response of a similar group of children whose primary vaccination was performed between the third and twelfth months of life. In this group response to annual re-vaccination should be noted yearly up to school age.
- (c) Study where laboratory facilities exist and children vaccinated at various ages are available of the vaccinal response to re-vaccination in correlation with the serum antibody titre such determination to be carried out immediately before and one month after the re-vaccination the choice of methods of titrating antibodies (complement fixation flocculation hæmo-agglutination) being left to the investigator.

The study group recommended that WHO take the necessary steps for field trials of the protective value of smallpox vaccine. These experiments are rendered necessary by the fact that potency tests of vaccines based on various dilutions of vaccinal virus taken from rabbits do not afford direct proof of the efficacy of vaccine in protecting man against smallpox. Such trials would be particularly

¹ *Chronicle WHO* 1948 - 141

It is interesting to note the difference between the fatality rates observed in true endemic areas, often as low as 7-10%, and in non endemic areas during epidemics, where they reach 50% and over

Factors governing endemicity

Research work was carried out in India up to 1942 on vibrios found in tanks and other stored water. *Vibrio cholerae* Koch was found only when clinical cases existed in the population using the tanks as their water supply, but not during cholera free periods

The presence of salt and organic matter was found to be essential to the survival of cholera vibrios, as without salt they died within 24 hours. These findings suggested that survival of cholera vibrio in water was not a proved factor in the persistence of cholera endemicity

The study group considered that further investigations should be carried out to determine whether the excretion of cholera vibrios from mild sub clinical cases of cholera could constitute a link between two cholera outbreaks

A number of methods were considered

- (a) A representative group of population in an endemic area would be subjected for at least one year to periodical rectal swabbing in order to detect carriers and establish a possible relation between the carrier state and mild diarrhoeal conditions
- (b) In selected areas endemic and non endemic all persons dying without medical attendance irrespective of cause of death should be subjected to systematic rectal swabbing to detect the presence of cholera vibrios
- (c) Teams of epidemiologists and bacteriologists familiar with conditions in one endemic area such as Bengal could study an endemic area in another country such as Southern China or Southern Indo China and compare conditions in the two areas for the purpose of determining factors governing endemicity

Numerous problems still remain to be solved, but will have to await further investigation. Among the most important are the possibility of a reversion from the rough to the smooth form of vibrio, which if it occurred in nature, would have important epidemiological repercussions. The incubation period referred to in

recommended for some time past by epidemiologists, for the eradication of the disease

Determination of Cholera Endemic Zones

Cholera has been reported recently only in China, India, Indo China, Pakistan and Siam. While in certain areas of these countries, such as Southern Indo China, there seemed to be a continuous presence of the disease but with a small number of cases (hypodemicity), in Bengal cholera with a much higher incidence prevailed continuously. But even in Bengal cholera was not constantly present in every district.

The study group agreed to define an endemic area as one in which over a number of years there is practically continuous presence of clinical cholera with seasonal exacerbations of incidence.

In India the following criteria have been suggested for the determination of endemic, non endemic and intermediate areas:

(a) *Percentage of months without cholera*

Endemic	less than 30%
Intermediate	30-50%
Non endemic	over 50%

(b) *Mean length in months of intervals between prevalence of cholera*

Endemic	less than 2.5
Intermediate	2.5 to 4
Non endemic	over 4

On the basis of the above criteria 80 out of 180 districts in Bengal were found to be endemic areas but none in Madras Province.

On the recommendation of the study group the WHO Secretariat will prepare world maps of recent cholera incidence and of cholera endemic areas, the essential criterion for the determination of endemicity being continuity of infection rather than the number of persons affected.

members of the study group, as well as the material collected by the WHO Secretariat, showed that trachoma was present in widely varying incidence in most countries, that it showed a high endemicity in various regions of Asia and in North Africa, and that it was endemic also in countries of Eastern Europe and in a number of American republics. It was practically non-existent in Australasia. It is thus easy to understand why WHO, like previous international health organizations, is paying particular attention to this disease which incapacitates millions of people annually.

Any action against the disease must be based on an exact knowledge of its geographical distribution. The study group, therefore, recommended that WHO should first obtain from governments up to date information on the prevalence of trachoma, based on returns from examination of schoolchildren, army recruits and samples of population, as well as on the proportion of trachoma cases to the total number of patients treated in ophthalmic hospitals and clinics.

Definition of Trachoma

The study group accepted the following definition of trachoma, a slight modification of that originally proposed by Dr A. F. MacCallan. Trachoma is a specific and communicable disease of the conjunctiva and cornea, showing at certain stages intracellular inclusions (Prowazek bodies). It has a tendency to become chronic and leads to cicatricial lesions of the tissues affected.

Causative Organism

The group agreed that, under certain conditions, the causal agent of trachoma was filtrable, noting that it showed some specific characteristics which placed it in a special group. The organism, which has been recently isolated and cultivated on chick embryos, bore close relationship to the virus of lymphogranuloma inguinale. In view of the importance of these findings the group recommended that this work should be repeated for purposes of confirmation.

Prophylaxis

Once the geographical distribution of a disease is known, the important thing is to prevent its spread. The study group agreed that the fundamental method of prophylaxis at present was the

sanitary conventions, a comparative study of the results obtained with Bandi's test and with the classical methods for diagnosis, results obtained with Sokhey's anti cholera vaccine

In view of the considerable number of problems still awaiting investigation by its members, the group recommended that the next session should not be held before the last quarter of 1949. It was unanimously agreed that it would be most useful to hold this session in a country where cholera is endemic and where the knowledge and experience of local experts could be readily made available to the group.

The group further recommended that WHO should make provision for the organization in 1949 of teams of cholera specialists and for their dispatch in 1950 to selected endemic areas. These teams will demonstrate in limited districts methods of cholera eradication, on the basis of the results expected from field studies, recommended by the group for 1948/49, of the factors governing cholera endemicity.

INTERNATIONAL PROPHYLAXIS OF TRACHOMA

The first session of the Joint OIHI/WHO Study Group on Trachoma was held in Paris from 9 to 11 October 1948.¹ The previous studies by the League of Nations Health Organization² and by

¹ The following members were present

Dr G. Blanc, Directeur de l'Institut Pasteur du Maroc, Casablanca, Morocco

Dr A. Macchiavello, U.S. Public Health Service, Consultant Epidemiologist
Pan American Sanitary Bureau, Lima, Peru

Dr C. C. Pandit, Secretary, Indian Research Fund Association, New Delhi, India

Dr Abdel Fattah El Tobgui, former Assistant Director, Memorial Ophthalmic Laboratory, Gizeh, Professor of Ophthalmology, Fouad I University, Cairo, Egypt

Dr J. Toulant, Professeur de Clinique ophtalmologique, Faculté de Médecine d'Alger, Algeria

Sir Aly Shousha, Iasha, Under Secretary of State, Ministry of Public Health, Cairo, Egypt, Chairman, Executive Board of WHO, and Professor A. R. Dujaime de la Rivière, Sous-Directeur de l'Institut Pasteur, Paris, France, also attended.

Secretariat

Dr M. Gaud, Directeur de l'Office International d'Hygiène Publique, Paris, who acted as chairman

Dr Y. M. Braud, Director, Division of Epidemiology, WHO

Dr M. M. Sidky, Medical Officer, Division of Epidemiology, WHO

Dr G. Stuart, Chief, Sanitary Conventions and Quarantine Section, WHO

² See bibliography in *Bull. Hlth. Org.* **L. o. V** 1945, 11, 187.

NOTES FROM THE FIELD

Philippines

A small medical teaching mission sponsored jointly by WHO and the Unitarian Service Committee of America is visiting the Philippines having left New York on 27 October. The team is composed of the following

Dr Howard C Naffziger Professor of Neurological Surgery University of California San Francisco USA

Dr J Murray Steele Professor of Medicine New York University College of Medicine New York USA

Dr Gumersindo Sayago Director of Medical Social Assistance for the Tuberculous Córdoba Argentina

Dr Jose Amador Guevera Director General Anti Venereal Disease League San Jose Costa Rica

Dr George Curtis Professor of Surgery Ohio State University School of Medicine Columbus Ohio USA

The Latin American members of the team were selected in co operation with the Pan American Sanitary Bureau

The Philippine Government is defraying the local expenses of the team and the money saved to WHO will be used for the provision of fellowships for the Philippines

China

News from the WHO staff in China is reassuring. Mr Morrill sanitary engineer who is in charge of the mission writes from Shanghai that members of the staff are still at their various posts and intend to remain there for the present except for Dr Pollitzer the plague expert who is at present on leave in the USA

Greece

Colonel D E Wright Chief of the Malaria and Sanitation Section of the WHO Mission left Athens on 1 October on retiring at the age limit. Colonel Wright has had a long career in Greece. He went to the country in 1930 and was engaged until 1937 on a general survey of malaria and sanitation problems for the Rockefeller Foundation. He returned to Greece in 1945 with the UNRRA Mission and his secondment from the Rockefeller Foundation was continued to WHO from 1 January 1947. He was responsible as far as any one individual can be for the introduction of modern techniques of insect control in Greece. Under his guidance the malaria service began a nation wide campaign for the control of malaria by the

treatment of cases. Sulfonamides and certain antibiotics had proved capable of relieving rapidly the clinical manifestations of trachoma and its associated infections, thus reducing considerably the danger of transmission. The group recommended that investigations be made into the relative efficacy, optimum dosage and mode of administration of these drugs at the various phases of the disease.

Individual treatment, however, is not enough, and certain collective measures are required. The group therefore agreed that as far as possible treatment should be extended to all patients through the medium of stationary or mobile clinics, special attention being paid to schoolchildren in view of the particular frequency of the disease at school age. It was felt that improvement in environmental hygiene combined with appropriate health education would be helpful in reducing the prevalence.

These measures should be complemented by a systematic international method of prophylaxis. The group unanimously agreed that it was legitimate for health authorities of immigration countries to have stricter requirements both in regard to eye examinations and to control measures, applicable to immigrants.

The study group, while considering that eradication of trachoma from its endemic foci was the ultimate objective of international control, agreed that international sanitary legislation should include measures designed to prevent the transmission of the disease from one country to another. Particular stress was placed on the desirability of sharply differentiating, in both international and national health legislations, between measures applicable to ordinary travellers and those applicable to immigrants. Measures concerning ordinary travellers should not exceed surveillance¹ of individuals showing on arrival an acute eye condition. Certificates, issued by ophthalmologists of national health administrations, might facilitate the work of quarantine officers and reduce surveillance requirements concerning individuals suffering from eye conditions resembling trachoma but of a different nature.

The final recommendation of the study group was that WHO should set up an expert committee on trachoma to co-ordinate research and to make available the results to health authorities and to the medical profession.

¹ "The word *surveillance* means that persons are not isolated but may be subjected to the places of arrival to a medical examination." International Sanitary Convention 1944. *UNRRI Epidemiol Inform Bull* 1945, 1: 247. They Inter

Streptomycin in Tuberculous Meningitis

The report of the Subcommittee on Streptomycin¹ was adopted without changes by the Expert Committee on Tuberculosis which nevertheless deemed it necessary to add the following statement

The committee would like to draw the attention of countries using streptomycin in tuberculous meningitis particularly in children to one important consideration—that they will have to make some additional provision for continuous hospitalization and convalescence facilities otherwise badly needed hospital beds will be blocked

Second World Health Assembly

The Executive Board at its second session accepted the invitation of the Italian Government to hold the Second World Health Assembly in Rome and decided that it should be convened on 13 June 1949. It is expected that the Assembly will last for approximately three weeks.

Third Session of the Executive Board

The Executive Board decided to hold its third session in the Palais des Nations Geneva beginning 21 February 1949.

¹ *Chronicle WHO* 1948 2 21.

use of DDT both as a residual spray and as a larvicide distributed by ground methods and by aerial spraying. The value of his work is shown in the tremendous reduction of malaria which has occurred in Greece.

The malaria control programme in Greece for 1948 would not have been possible without the assistance of the US Mission of Aid to Greece. It was completed for practical purposes by 15 September for residual spraying and 10 October for aerial spraying and ground larvicide measures. 4 730 communities have been treated with DDT residual spray as compared with 5 266 in 1947. The disturbed state of the country has unfortunately considerably handicapped the programme in 1948 e.g. 2 722 flying hours were completed by the aerial spraying section as compared with a proposed total of 4 870. The acreage sprayed was 702 705 compared with a programme of 1 217 42.

WHO is co-operating with representatives of the Rockefeller Foundation in a sanitary survey of the island of Crete.

NOTES AND NEWS

Plague

The Joint OIHP/WHO Study Group on Plague and Typhus (see also p. 252) recognized that the occurrence of human plague depends originally on transmission to man from rodents by their ectoparasites. It also agreed that the human flea *Xulex irritans* can be infected in nature and that exceptionally it can acquire infection from men and transmit the infection to animals. Further investigations are required to elucidate the epidemiological role of this parasite.

In view of the existing uncertainty regarding the presence of plague among wild rodents in certain parts of the world, particularly in Africa, the group recommended that WHO should appoint a team of investigators comprising an epidemiologist, a zoologist and an entomologist to delimit enzootic plague zones on the spot.

The group studied the favourable results obtained with live vaccines in the prophylaxis of human plague. It considered that in view of the short duration of immunity given by anti-plague vaccines and of the fact that rodents and not men constitute the plague reservoirs, vaccination could not be considered as a means of eradicating human plague and that it was of less importance than measures taken against rodents and ectoparasites.

Dr Macchiavello agreed to undertake the drawing up in accordance with a uniform and modern nomenclature of a list of animals and their ectoparasites capable of acting as vectors of plague.

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

VOL. II, No 12

December 1948

NEW INTERNATIONAL EFFORT AGAINST VENEREAL DISEASES

Many aspects of the control of venereal diseases are now under going major changes. In the treatment of syphilis, penicillin has removed many of the dangers and drawbacks formerly associated with arsenic, heavy metal and other therapy. Results are spectacular, particularly in the treatment of infected pregnant women, and 95% of the offspring of such women treated with penicillin are born healthy, regardless of trimester of pregnancy in which the mother is treated. As a result of the introduction of sulfonamides and penicillin, gonorrhœa, if properly treated, is no longer to be regarded as a very serious disease. Gonococcal infection of the eye and genitalia in children can now be successfully treated with penicillin. Finally, new hopes arise from the treatment with streptomycin of granuloma inguinale¹. A recent study of 25 patients suffering from lymphogranuloma venereum treated with a new antibiotic, aureomycin, shows results justifying extensive research and clinical trials².

While new treatments have greatly advanced the possibility of venereal disease control, the limited availability and unequal distribution of penicillin restrict their application. Plans for mass treatment demand large quantities of the drug, and countries deprived of it are consequently prevented from launching extensive

¹ *Granuloma inguinale* here means the disease of which the causal agent was described by Donovan in 1905; the term *lymphogranuloma venereum* on the other hand, is applied exclusively to the disease described by Nicolas and Favre in 1913.

² Wright L. T., Sanders M., Logan M. A., Ingot A. & Hill M. L. (1948) *J. Amer. med. ass.* 133: 408.

PUBLICATIONS OF THE WORLD HEALTH ORGANIZATION*

WEEKLY EPIDEMIOLOGICAL RECORD

(Bilingual English and French)

This publication intended for national health administrations and for health services at ports and frontiers contains notifications concerning diseases qualified as pestilential in the International Sanitary Conventions as well as other information about the application of the Conventions.

It is mainly intended for official use and is not for sale separately. It can however be obtained in conjunction with the *Epidemiological and Vital Statistics Report* (see below).

EPIDEMIOLOGICAL AND VITAL STATISTICS REPORT

(Bilingual English and French)

The *Report* is published monthly and contains statistics on infectious diseases mortality rates etc. The statistical information is supplemented by various articles and notes on epidemiological and demographic subjects.

Subscription for 1949	22/	\$2.00
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Price per single copy	2/6	\$0.50
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Annual subscription including the *Epidemiological and Vital Statistics Report* and the *Weekly Epidemiological Record* for the use of libraries, medical schools etc.

	£2	\$8.00
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OFFICIAL RECORDS OF THE WORLD HEALTH ORGANIZATION

(Separate editions in English and in French)

This publication contains the minutes of the meetings together with the reports and documents of the World Health Organization and its principal organs: the Interim Commission, the World Health Assembly and the Executive Board.

Eleven volumes have so far been published and four others will appear shortly.

Price per single copy	1/3	\$0.25
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Price for No. 13 — First World Health Assembly	2/6	\$0.50
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* All prices are post free

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£2	\$8 00
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At the two sessions, requests from certain European countries for assistance in the control of prenatal and infantile syphilis were studied. It was decided that the WHO Expert Committee on Venereal Infections should be consulted and its advice sought on the medical aspects of the development of the programme. The Expert Committee on Venereal Infections, which held its second session from 15 to 19 October in Paris,⁵ believed that assistance in combating prenatal and infantile syphilis should preferably be granted

- (a) to countries where a structure for venereal disease control exists, and where the introduction of penicillin treatment would serve to stimulate the control work in such a way that a mass attack against syphilis might be carried out,
- (b) to countries in which a particular section of the population is involved and where a special endemic problem may exist,

⁵ The following were present at this session

Members

Dr W. E. Coutts	Chief Department of Social Hygiene Public Health Administration Santiago Chile
Dr G. L. McElligot	Adviser on Venereal Diseases Ministry of Health London United Kingdom
Dr J. F. Mahoney	Medical Director Venereal Disease Research Laboratory (United States Public Health Service) Staten Island N.Y. USA
Dr R. V. Rajam	Professor of Venereology Principal Medical College University of Madras Madras India
Dr S. Hellerström (Corresponding member)	Professor of Dermato-syphilology University of Stockholm Sweden

Consultants

Dr H. Brun Pedersen	Venereal Disease Control Officer Danish Maritime Services Copenhagen Denmark
Dr E. H. Hermans	Medical Director Venereal Diseases Port of Rotterdam Holland

Observers

Mr J. L. Mowat	Chief Maritime Division International Labour Office Geneva
Dr A. Cavaillon	Secretary General International Union against Venereal Diseases
Dr D. Borensztajn	Inspector General Venereal Disease Control Division Polish Ministry of Health Warsaw Poland

Secretary

Dr T. Guthe Member of the Secretariat of WHO

Dr M. Grzybowski Chief Clinic of Dermato-syphilology Professor University of Warsaw Poland was unable to attend

The report on this session of the expert committee will be published in *Off Rec WHO 15*.

national campaigns against venereal diseases. Specialized personnel, medical literature, technical advice, and information on new methods of treatment are also urgently needed by many countries.

Many of these difficulties can be overcome only by international co-operation, and it is natural that several international organizations should be interested in the question. Indeed, most of those who are now engaged in international campaigns against venereal diseases are not breaking new ground. The Office International d'Hygiène Publique and the Health Organization of the League of Nations deserve credit for the fruitful activity developed during their existence.

The financial resources of these institutions were, however, limited and at no time permitted an extensive international campaign. The recent allocation of \$2,000,000 to venereal disease control by UNICEF is therefore to be regarded as a decision of paramount importance. The international programmes discussed in this article and the nation-wide Polish campaign against syphilis³ are signs of a far-reaching change of attitude. Defensive measures, arising out of conditions which prevailed until a few years ago, have been abandoned in favour of a more aggressive approach, aiming at eradication of venereal diseases throughout large parts of the world.

The money allotted by UNICEF for combating syphilis in pregnant women and in children up to 18 years of age will be allocated in the near future according to the plans drawn up by a Joint Committee on Health Policy of UNICEF/WHO, set up early this summer. The joint committee⁴ has already met twice, the first time on 23-24 July in Geneva, and the second time on 19-20 October in Paris.

³ An article on this campaign will appear in a future number of the *Chronicle*.

The following were present

at the first session		at the second session	
UNICEF	Mr L. J. R. Heyward	UNICEF	Prof R. Debré
	Mr M. Iate		Mr E. J. R. Heyward
	Dr L. Rajchman		Dr L. Rajchman
	Dr B. Schober		Dr Y. T. Wu
	Dr Y. F. Wu		
WHO	Dr K. Evang	WHO	Dr C. van den Berg
	Dr H. van Zile Hyde		Dr H. C. van Zile Hyde
	Dr M. Mackenzie		Dr M. Mackenzie
	Dr A. Stampar		Dr A. Stampar
<i>Secretaries</i>		<i>Secretary</i>	
	Dr B. Bortlé		Dr B. Bortlé
	Dr W. Forrest		

Asia

The committee was in agreement, in principle, with the UNICEF Survey Mission that it would be of considerable importance to initiate penicillin treatment of prenatal and infantile syphilis in Asiatic countries. The value of such penicillin programmes would be in the teaching of the new methods and their effect on medical opinion rather than in actual contribution to a decline in syphilitic infection in such regions. Only through the gradual expansion of demonstrations could a more lasting contribution to the organization of venereal disease control be made and important benefits be derived from the use of penicillin in areas with a high prevalence of syphilis.

The UNICEF Survey Mission had recommended that penicillin be made available in India and Pakistan for women and children in groups of displaced persons. The committee felt, however, that because of practical difficulties which might arise from the reported large number of displaced persons, the soundest procedure would be to establish pilot demonstrations in clinics where such groups could be treated. Such demonstrations would be of the greatest value when the area selected contained training and teaching facilities. In India, clinics might be selected in the cities of Madras, Calcutta, Bombay or Delhi, alternatively penicillin allocated to India might be used by the WHO field demonstration and consultation team requested by the Indian Government and recommended by the expert committee for 1949. In Pakistan, further information should be obtained as to a suitable demonstration centre, the committee suggesting clinics in Karachi or Lahore. The UNICEF Survey Mission to the Far East had previously proposed that in the case of Siam a demonstration centre should be organized in Bangkok.

Fellowships

The committee studied the requests received for fellowships under the prenatal and infantile syphilis programmes and agreed that the granting of such fellowships should be co-ordinated with the field work, so that fellows returning from study tours should carry forward the demonstration programmes. In view of the importance of these initial demonstrations in forming medical opinion in the countries concerned the highest technical standards should be required of the prospective fellow.

- (c) to countries where pilot demonstrations in a limited number of clinics and hospitals can be established and where facilities for teaching and training exist

Europe

The committee was of the opinion that the information submitted by Bulgaria, Finland, Hungary and Yugoslavia showed that programmes for combating prenatal and infantile syphilis in these countries could be put into operation through the already existing venereal disease clinics and the maternity and child health centres. Such programmes, the committee believed, should be initiated through pilot demonstrations in clinics or hospital centres of repute before the work is extended. During this demonstration period, the national health administrations should be training medical personnel in the clinical and other methods employed. Serological units should also be established, for these are essential to diagnostic and follow up procedures in any programme for the treatment of syphilis with penicillin.

In the case of Yugoslavia attention was drawn to the desirability of a mass attack with penicillin on the endemic syphilis which is known to exist in Bosnia Herzegovina and which was surveyed in 1934 with the help of the Rockefeller Foundation. Previous attempts at treatment with arsenic and bismuth had failed because of the prolonged period of treatment necessary and special geographic social and economic conditions but the area is particularly suitable for a penicillin programme in view of the great prevalence of the disease. Such a project the committee believed would be of international as well as national interest since similar endemic areas of high prevalence exist in other parts of the world particularly in Asia and Africa.

The committee considered that the requests from the governments of Albania, Czechoslovakia, Greece, Italy and Roumania should be studied and that experts on venereal diseases appointed by WHO should visit these countries to initiate demonstrations which might form a basis for the establishment of broader prenatal and infantile syphilis programmes and increased anti venereal disease activities.

Finally, the committee noted that the Italian Government, on the basis of the experience acquired from the demonstration programme now in operation in Naples, has requested that this programme be expanded to cover other areas.

the Economic Co operation Administration, while the various international and national voluntary agencies have given generous help

The chief objective has been to create a tuberculosis conscience. This is being attempted by such means as the creation of a tuberculosis section in the Ministry of Hygiene, the establishment of a Chest Institute in Athens which will include, among other activities, a model diagnostic centre where modern statistical methods will be demonstrated, by stimulating the development of dispensaries, especially in the provinces, by the training of nurses both in institutional and public health procedures, by the inception of mass radiography examination, by disseminating knowledge of modern advances in tuberculosis work, including BCG, chemotherapy, and rehabilitation, by supporting the reconstruction of new hospitals and sanatoria, by erecting and repairing x ray installations brought in by other agencies, among the profession by literature, fellowships and visiting lecturers, and by affording technical advice on such questions as the distribution of medical supplies (e.g., x ray films and streptomycin), ration scales for the tuberculous and the law on tuberculosis specialists. The objectives have, by and large, been attained, but only after prolonged efforts and tedious delays—none the less exasperating because often caused by circumstances over which neither the Greek health authorities nor WHO had any control.

The project for a Chest Institute arose out of the successful development of a mass radiography centre at Rissarion Hospital, Athens, opened in April 1945. It was decided to expand its activities and transfer them to a more suitable building, and by January 1947 the WHO Adviser reported that the charter of the new institute was ready for signature. By April 1948, the physical transfer to the new building was being effected and a committee of grim and determined men and women was on the point of seeing the project successfully concluded, in spite of innumerable difficulties.

As for the Tuberculosis Association, this very valuable adjunct of a tuberculosis scheme has had many financial and other difficulties but has done good work in propaganda by pamphlets (100,000 copies of the eighth pamphlet on prevention and therapy were distributed) and the publication of a bulletin and a nursing textbook. But for the mission's support and encouragement, the Association would hardly have survived until now.

Procurement of penicillin

Members of the joint committee agreed that WHO should assist UNICEF in the procurement of penicillin and should take steps to ensure that supplies obtained are of acceptable quality and in conformity with recommended standards. The penicillin preparations to be used should be of the crystalline type G, preferably in beeswax oil or in procaine with 2% aluminium monostearate. Treatment in the prenatal and infantile syphilis programmes should follow the acceptable treatment schedules suggested by the expert committee.

The expert committee noted that penicillin plants given by UNRRA to certain European countries were still not in operation. Funds were allocated by the first World Health Assembly for survey of the requirements of these plants before they could undertake production.

Since UNRRA residual funds may be transferred to the United Nations and UNICEF, it was decided that the attention of the latter organization should be directed to the desirability of bringing these plants into operation through UNICEF funds. It was also suggested that the question should be placed before the United Nations Economic Commission for Europe in view of its interest in industrial rehabilitation.

TUBERCULOSIS IN GREECE

The anti tuberculosis work of UNRRA and other agencies until the beginning of 1947 has already been described by Dr J B McDougall¹. The following notes on the work accomplished by the tuberculosis section of WHO in the Greek Mission carry the story from 1947 to the present time.

Tuberculosis shares with malaria the distinction of being the major post war health problem of Greece—indeed, the success of the antimalaria campaign has now raised it to undisputed leadership. The WHO aid is now limited to advisory duties and a small staff can achieve—and has achieved—valuable if limited results. Assistance in the Government's fight against this disease has recently arrived through the American Mission for Aid to Greece (AMAG), the public health division of which has now been incorporated into

¹ Bull. WHO 1947 1: 103 abstract in Chronicle WHO 1947 1: 184

EUROPEAN HEALTH CONFERENCE

As a result of the conference organized by WHO in Geneva on 15 and 16 November, attended by representatives of 17 European countries devastated by the war,¹ the decision was taken to establish a temporary special office in Geneva for health rehabilitation in Europe.

This meeting was of particular interest as it was the first time since the war that representatives of European countries were able to give all their attention to reviewing the health of their people and to discussing possibilities for its improvement. A questionnaire had been issued by WHO to various governments, asking them to indicate the kind of help required, particularly with regard to malaria, tuberculosis, venereal diseases, maternal and child health, nutrition and environmental hygiene. This help could be provided by sending experts, supplying drugs, medical literature and medical equipment, and by granting fellowships.

Replies to the questionnaire, and discussions which took place during the conference, gave a similar picture for most of the countries of post war Europe: increased tuberculosis morbidity and mortality rates, the spread of venereal diseases, mounting figures of general, infant and infectious disease mortality, and the sporadic recurrence of diseases formerly under control. In Austria, Norway, Poland and Yugoslavia, the partial destruction of hospitals and medical schools and the closing of universities during the war have aggravated the acute shortage of hospital buildings and the need for training new medical and nursing personnel. For these reasons, nearly all countries are asking for fellowships so that their nationals might continue their studies abroad and familiarize themselves with modern techniques.

The general need for medical equipment and supplies, and for drugs or chemical products, such as penicillin and DDT, was also discussed. This is one aspect of the vast economic problem of production and distribution confronting Europe today. An adequate supply of penicillin, for example, would do much to improve European health conditions, but many countries have not yet started active production of this drug. The task of WHO will be to approach the United Nations Economic Commission for Europe and to provide a general outline of the needs of European countries in this direction.

¹ For list of representatives see p. 277

Training courses in tuberculosis nursing for 250 nurses, lasting three months, have been held at the two largest sanatoria in Athens. Given by nurses rather than physicians, they have been a great success. It is in this work that the reduction in staff has had the most serious effects since clearly no more courses are possible with only one nurse left in the mission, combining general duties with her tuberculosis advisory work. The maintenance of x ray installations sent in by UNRRA and other agencies has proved a difficult problem. After a number of x ray sets had been erected and clinics started, subsequent inspection showed that some had ceased to function through breakdown, damage, requisition of buildings or removal of apparatus or because the staff had left for various reasons, mainly lack of funds and military obligations. Nevertheless of 51 tuberculosis dispensaries in Greece, 45 are working, although only 25 can be considered satisfactory—a considerable advance although it clearly does not meet the need.

Early in 1948, a pilot team of the Danish Red Cross, using the Copenhagen vaccine and technique made a successful demonstration of large scale vaccination, and recently following the signing of an agreement between the government and the joint enterprises (UNICEF, WHO, and the Scandinavian Red Cross and relief societies) the international tuberculosis campaign by mass BCG vaccination has been extended to Greece.

Unknown except by name before the war in Greece, occupational therapy has now been definitely placed on the map, largely through the untiring efforts of one foreign voluntary worker, aided by the WHO mission and the Hellenic Red Cross. A demonstration section at Sotiria Sanatorium has been soundly established. Extracts from recent reports state that we have been able to make the indispensable cupboards and furniture out of the American Red Cross packing cases. Temporary teaching staff includes a librarian, a bookbinder, an artist and film operator, an entertainment officer and dressmakers. Plans include the development of leather work, broom making, book keeping and film projection.

These notes deal primarily with central problems. The mission's small staff—as their reports show—have also found time to visit, report and stimulate anti tuberculosis activities in nearly every part of the mainland, the islands, Crete and the Dodecanese.

These are a few of the facts which came to light during the conference. The broad outline of the problem is now clear. In recommending the setting up of a temporary special office for health rehabilitation in Europe, various States showed their willingness to co-operate closely. It will be the particular function of this new WHO office, working in collaboration with the health administrations of European countries, to make full use of the advantages of international co-operation, to achieve, as quickly as possible, the improved standard of health so vital to the general reconstruction of Europe.

GOVERNMENT REPRESENTATIVES ATTENDING THE CONFERENCE

AUSTRIA	Mr C. Strobl, Counsellor, Ministry of Social Affairs, Vienna
BELGIUM	Dr J. I. Goossens, Directeur général au Ministère de la Santé publique et de la Famille, Brussels
BULGARIA	Dr C. Koussitassov, Vice Minister of Public Health, Sofia
CZECHOSLOVAKIA	Dr E. Ungar, Director of Department IV, Ministry of Health, Prague
DENMARK	Dr J. Holm, Chief, Tuberculosis Division, State Serum Institute, Copenhagen
FINLAND	Dr L. A. Kaprio, Provincial Health Officer, State Medical Board, Helsinki
FRANCE	Dr N. Leclainche, Inspecteur général de la Santé, Ministère de la Santé publique et de la Population, Paris
GREECE	Dr T. Catsoyannis, Director of Hygiene, Athens
HUNGARY	Dr A. Kálman, Director, Ministry of Social Welfare, Budapest
ITALY	Professor G. A. Canaperia, Chief Medical Officer, Public Health Department, Rome
LUXEMBURG	Dr I. Molitor, Directeur de la Santé publique, Ministère de la Santé, Luxembourg
MONACO	Dr E. Boeri, Directeur du Service d'Hygiène et de Salubrité publique, Monaco
NETHERLANDS	Dr C. van den Berg, Director General of Public Health, Ministry of Social Affairs, The Hague
NORWAY	Dr J. L. Caspersen, Deputy Surgeon General of Norway, Oslo
POLAND	Dr B. Kozusznik, Vice Minister of Health, Warsaw
UNITED KINGDOM	Dr M. Mackenzie, Principal Medical Officer, Ministry of Health, London
YUGOSLAVIA	Dr Olga Milošević, Secretary General of the Red Cross of Yugoslavia, Belgrade

During the discussion delegates gave precise details of the position in their countries. The representative for Poland showed the disproportion existing between the means at the disposal of his country and the problems which it must face. Poland would need 20,000 doctors in order to ensure the normal working of its health services, but there were only 6,500 at the end of the war. The nine medical study centres have not the necessary technical and material means to train medical personnel. Help from WHO would be particularly useful in this respect. With assistance from WHO, Poland has just undertaken very extensive campaigns against tuberculosis² and venereal diseases³. Twenty nursing schools have recently been opened.

In Yugoslavia 40% of the hospitals were destroyed. Infant mortality has increased considerably and it is estimated that 80 000 children are suffering from tuberculosis and 100,000 exposed to infection. This country thus urgently needs medical equipment, drugs, food for children and means of transport. Transport is also lacking in Finland, where great distances make it difficult to check the health of the population. In northern Norway all the hospitals destroyed during the war must be rebuilt and re-equipped, and 10 000 hospital beds are urgently needed. The absence of medical training centres forces many Norwegian students to go abroad and fellowships are a primary necessity for this country. Finally in Czechoslovakia, tuberculosis has increased considerably, the mortality rate being 160 per 100,000 inhabitants, while treatment is made difficult by the lack of streptomycin. Venereal diseases also present a serious situation. Help accorded in this respect by UNICEF, in collaboration with WHO, for the treatment of syphilitic children and pregnant women reaches only one third of the total number of patients.

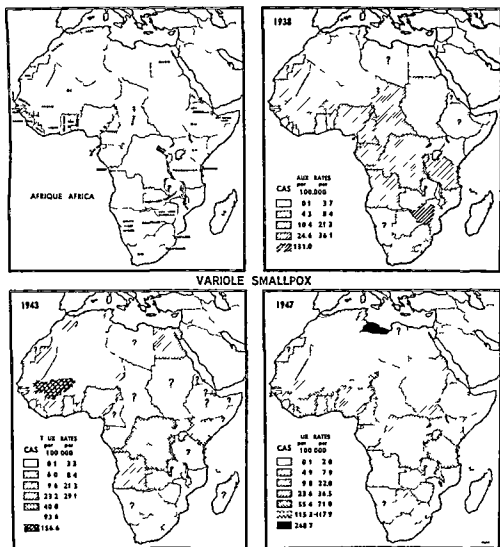
Countries such as Belgium, France, Luxembourg and the Netherlands which have suffered less but whose standards of health compared with pre-war have fallen have limited their requests to the sending of experts and educational equipment so that the small funds which WHO will be able to allot for medical help for Europe will benefit the countries where the position is more critical.

² *Chronicle WHO* 1948 - 10

³ An account of the Polish anti-syphilis campaign will be published in a forthcoming number of the *Chronicle*.

rise to the highest morbidity rate of the last half century although having at the same time a low case fatality rate of less than 9%

Fig 1 Incidence of Smallpox in Africa 1938 1943 1947



The indigenous population of the black continent remains, however, an immense source of infection. In the Belgian Congo, for example, vaccination performed annually on 1,500,000 inhabitants does not always produce the expected results. Tropical conditions make vaccination difficult. Owing to the heat, glycerinated lymph rapidly loses its virulence during vaccination tours and transport over long distances. The use of heat resistant dry vaccine, free from foreign organisms, could solve this problem. On the other hand,

WORLD PREVALENCE OF SMALLPOX during and after the second World War

The second World War has not been followed by the serious epidemics which seemed inevitable after wars in the past, but in most continents there has been a recrudescence of smallpox.

Figures relating to smallpox morbidity and mortality are not always exact, as it is difficult to obtain statistics and complete data for all countries, especially for the war years. Sufficient material is, however, available to give a general view of the prevalence of the disease during the last ten years. A survey has been made by Dr J. Fabre in a well documented article in which health conditions, in so far as they are related to smallpox, are reviewed for the various parts of the world¹. The author concludes that the war and the period immediately following have had marked repercussions on smallpox incidence throughout the world, in spite of many regional variations.

Europe

Europe, however, has escaped the fate of other continents. In contrast to the situation in 1919, at the end of the first World War, when 300,000 cases of smallpox occurred, Europe can now be considered practically free from the disease. During the last few years the only epidemic recorded was a shortlived one in Sicily, imported from North Africa, which subsided after having invaded Southern Italy. Isolated cases, introduced from other continents, were recorded in Belgium, France, Germany and Great Britain, and in 1943/44 an epidemic originating from the Near East, broke out in Greece.

Africa

In Africa after a new outbreak of smallpox between 1940 and 1947 the satisfactory situation existing before the war, as a result of persevering work carried out over a period of many years, is being restored. Such is the case particularly in Algeria, Egypt, Morocco and the Union of South Africa.

An interesting comparison between the epidemics which raged in Egypt in 1904 and in 1944 shows that the latter epidemic gave

¹ *Epidemiol. et Stat. Rep.* 1948, 1, 26.

Asia

The military operations from which China suffered during 1939-1947 favoured the spread of smallpox in many parts of the country. The situation remains serious, as in the first six months of 1947 16,000 cases were estimated, with a fatality rate of about 20%. In Japan before the war, the incidence of smallpox had been reduced to a very low rate, in 1938 only six known cases were reported, but a violent epidemic broke out in 1946, abating noticeably in 1947.

India experienced very serious epidemics among populations weakened by famine in 1944 and 1945, a large proportion of children under 10 years of age falling victim to the disease. The vaccination campaign was intensive, 20,500,000 persons being vaccinated in 1945 in Bengal, and in 1946 the morbidity and mortality rates had become once more practically normal.

In 1940, Iraq was the centre of an epidemic from which infection spread to most countries of the Near East, Syria and Turkey. The epidemic was most serious in the last named country, with an incidence rate unequalled for many years and a fatality rate of as much as 20% in non vaccinated cases. The epidemic spread even to European Turkey and to Greece. Thanks to energetic prophylactic measures and to extensive vaccination campaigns, the epidemic declined in intensity in 1941 and subsided in 1946-47.

It appears from Dr. Fabre's survey that the privileged position of certain regions of the world does not affect the need for constant vigilance, as the speed of present means of communication exposes all countries to contamination by diseased persons coming from endemic smallpox regions.

WORLD BRUCELLOSIS CENTRE

It is expected that a World Brucellosis Centre will shortly be set up by WHO to collect and disseminate information to workers engaged in research on this disease.

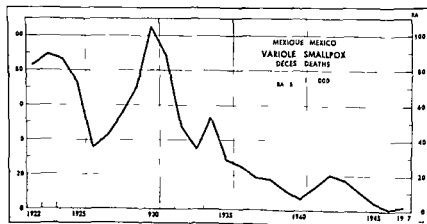
During the first Health Assembly, a discussion on the brucellosis problem revealed that the disease had different manifestations in different countries and that it was necessary for scientific research to be carried out nationally in national or regional institutions.

natives try to neutralize the vaccine by exposing scarifications to the sun, by treating them with acid fruit juices or by mechanical means and often succed if they are not closely watched. In Natal, natives are opposed to vaccination for religious reasons.

America

Canada is practically free from smallpox: no death has been reported since 1940. In the United States, 173 cases were reported in 1947, but in certain States only: others being free from the disease. It is interesting to note in this country the influence of vaccination on the incidence of smallpox and to recall the heated controversy on the value of smallpox vaccination. Dr Fabre points out that in the United States there is a clear relationship between the decrease in the incidence of smallpox and the stringency of vaccination measures. During the period 1938-1941, the mortality rate was 13.2 per 100,000 inhabitants in the States where vaccination was not compulsory, and 0.8 per 100,000 in States where children were vaccinated before school age.

Fig. 2. Smallpox in Mexico 1922-1947



Mexico furnishes another example of the success of prophylactic measures applied over nearly 50 years. Although still prevalent in Central and Southern States, smallpox is declining rapidly as shown in fig. 2. But this country, as well as Peru and Bolivia, must be considered as still forming active foci of smallpox and possible sources of continuation.

NEW STUDY OF RABIES

Wide differences of opinion are known to exist concerning the treatment and prophylaxis of rabies. The value of vaccination is at present being questioned¹. On the other hand, prophylaxis by animal vaccination, which has been advocated for some years, has only been adopted by a few countries.

For these reasons, during the first Health Assembly, the Hungarian delegation requested that the Assembly recommend the introduction of the preventive vaccination of dogs in all countries where rabies is endemic. This measure, compulsory in Hungary for many years, has resulted in the virtual eradication of canine rabies in that country. The Pasteur Hospital was therefore closed on 1 January 1942, and the institute taken over by the Health Institute. It now prepares only animal vaccine². The Hungarian delegation had moreover requested that the Assembly recommend the decentralization of the vaccination of persons bitten by rabid animals. The treatment of persons on the spot, in hospitals, dispensaries, or even at home by a simplified technique replacing the long term treatment given in specialized institutions has in fact been practised with success in many countries.

The Executive Board, which was entrusted with the study of this question, has asked the WHO Secretariat to inquire into the present position regarding anti-rabies vaccination and prophylaxis. The Secretariat will also examine those recommendations made by the International Rabies Conferences of Paris, 1927, and of Bucharest 1938, upon which no action has yet been taken. Finally, the Secretariat will study the latest proposals of rabies specialists on the most efficient anti-rabies control methods. The conclusions of this inquiry will be submitted to a group of experts which will decide whether the convening of a new international rabies conference would serve any useful purpose.

¹ See Greenwood M (1946) *Bull. Hlth Org.* 1: 501

² Cortway, Director of the Hungarian Health Institute (October 1946) quoted by Remlinger I (1948) *Biol. med.* 37: 12.

Some such institutions already exist in various countries,¹ and others will certainly be set up in the future. One of these regional centres would be chosen as a world centre.

Among the subjects of particular interest are the detection of brucellosis in man and animals, the incubation period and the modes of communication. The efficacy of various types of vaccine, whether of live or killed organisms, the value of methods of treatment such as serum treatment, protein shock therapy, and intramuscular injection of brucella should also be studied. According to recent data, combined streptomycin and sulfadiazine treatment has given satisfactory results in certain cases.² It would be advisable to estimate the results of the vaccination of exposed persons and of healthy herds as well as of infected persons and animals.

In diagnosis it is difficult to distinguish between the three types of brucella which are pathogenic to man. Transitional strains exist between these types and the serological typing of brucella raise complex problems different from those associated with salmonella in which each of the multiple forms is agglutinable with a type specific anti serum. Finally where the infection is milk borne, intensive propaganda for the control of milk and milk products should be initiated. Persons whose work involves close contact with cattle or who have to handle meat should be advised to take precautionary measures.

Brucellosis constitutes a grave threat to livestock, thus causing a serious loss of meat products and having economic repercussions which must be taken into account. As this disease affects both the health of man and production of food, WHO has approached FAO so as to collaborate in studying those aspects of the problem which are of interest to both organizations. FAO has decided to place brucellosis on the agenda of an animal disease conference to be held shortly in Poland.

¹ Such centres are to be found for example in Montpellier (France) and in Florence (Italy). The Institut Pasteur in Algiers and Tunis also have special laboratories for research.

² Pula ki L. J. & Amacher M. H. (1947) *Bull. U. S. Army med. Dept.* 7: 21.

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¹ See Greenwood M (1946) *Bull. Hlth Org.* 1: 301

² Cortway, Director of the Hungarian Health Institute (October 1946) quoted by Remlinger P (1948) *Biol. med.* 37: 12.

UNITED NATIONS CHARTER ON THE RIGHTS OF THE CHILD

A United Nations Charter on the Rights of the Child is in course of preparation. The charter will restate the general principles of the Declaration of the Rights of the Child, commonly known as the Declaration of Geneva, which was promulgated in 1923 by the International Union for Child Welfare and adopted by the League of Nations. This declaration which had become widely known, was responsible over many years for much legislation affecting children but its revision has become necessary in the light of changing ideas.

WHO having been asked for its opinion on certain amendments to be added to the Declaration of Geneva, has expressed the wish that the new document should take into account the essential principles formulated in the preamble to the Constitution of the World Health Organization and should include among the fundamental rights of the child the right to proper care, so as to ensure the enjoyment of the highest attainable standard of health.¹

In addition WHO has expressed the hope that fundamental health services be made available to each child—in the prenatal period by care of the mother—and that no effort be spared in the development of existing health services to promote both physical and mental health. The child should be protected against epidemics and provision made for adequate care, housing and nutrition as well as medical care and supervision. Recreation and physical culture should be provided at all ages.

In view of the importance of mental and emotional factors in the harmonious development of the child WHO has suggested that it be clearly recognized that the child should develop in an atmosphere of affection and security even if deprived of a normal, healthy family life. The child should also be assured an education which will foster development of its intellectual faculties and lead to the acceptance of responsibility in the home and eventually, in the national and international community.

In pursuance of these principles WHO has proposed additions and modifications to various articles of the draft Declaration of the Rights of the Child. The Executive Board of WHO has transmitted

¹ See Constitution of WHO *Chronicle WHO* 1947: 1-29

these proposals to the Social Activities Division of the United Nations for consideration when the final Charter of the Rights of the Child will be prepared

ERADICATION OF ANOPHELES GAMBIAE FROM EGYPT

Anopheles gambiae is the most harmful malarial vector in Africa where it has already caused serious epidemics. In 1942, it appeared in Egypt, coming probably from the centre or the south of the continent. Volume 1 No. 2 of the *Bulletin of the World Health Organization* contains a detailed study by Sir Aly Shousha, Pasha, on the ravages caused by the sudden incursion of this insect and on the energetic control campaign by which Egypt was rid of this dangerous intruder.

The first malarial epidemic in Egypt attributed to *A. gambiae* broke out in Lower Nubia in 1942. In certain villages, the monthly mortality rate increased from the normal of 2.5 per 1,000 inhabitants to 34 per thousand in May 1942. Economic losses resulting from lowered working capacity in a single property of approximately 12,000 hectares amounted to nearly ££500,000 in 1943 and 1944.

The infested region comprised a strip of cultivated land in the flood plain of the Nile between Ballana in the South and Asyut in the north, with an area of 4,270 square kilometres and a population of three million.

Irrigation measures, in multiplying possible breeding places for larvae, favour the increase of *A. gambiae* during certain times of the year. To be effective, control measures against the mosquito should be carried out especially in the summer and autumn. Those undertaken by the Egyptian public health authorities, the planning of which is described in detail by Sir Aly Shousha, Pasha, were devised for the extermination of the mosquito, special attention being paid to larvae.

The infested region was divided into 641 zones, within which the campaign was carried out systematically by teams who treated larval breeding places with Paris green or oil according to local conditions and materials available. The work of these teams was very carefully checked, as only by the strictest adherence to the methods prescribed could the objective, the total eradication of *A. gambiae*, be attained.

Owing to shortage of pyrethrum and particularly of DDT, no systematic disinsectization of houses was practised, but to prevent the spread of the insect from the infested area to the uninfested area to the north, trains, automobiles, boats and aeroplanes were disinsectized.

Therapeutic services were organized in conjunction with the mosquito control campaign. Notification of malaria had been compulsory since 1930, but the notification system was improved and the mortality rate was considerably lowered by the immediate treatment of reported cases.

These vigorous systematic measures were relentlessly carried out in spite of considerable difficulties caused by the war in 1942 and 1943, and resulted in the eradication of *A. gambiae* from Egypt, the mosquito being reported for the last time in February 1945. The success of this intensive campaign against *A. gambiae* shows once more—as with the comparable campaign carried out in Brazil in 1938¹—that species eradication is possible even over a wide area and that it is not an expensive luxury when the cost is compared with the devastating effect of so dangerous an insect as *A. gambiae*.

¹ See Sojer F. L. & Wilson D. B. (1943) *Anophele gambiae* in Brazil 1930-1940. New York.

RESIDUAL TOXICITY OF DDT

The report on the second session of the Expert Committee on Malaria¹ gives a clear indication that, as a result of the discovery of the remarkable residual toxicity of DDT, malaria control in rural areas will in future be effected mainly by an attack on the adult mosquito. But an accurate evaluation of this residual toxicity is needed to determine the best method of application under varying conditions.

In a recent article² Dr E. J. Pampana, secretary of the Expert Committee on Malaria, reviews the different methods and techniques devised during the last few years for such an evaluation. Laboratory experiments have been used to measure the residual toxicity in relation to the time during which a mosquito is exposed to the

¹ *Off. Rec. WHO* 11: 43. An abbreviated version appeared in *Bull. WHO* 1948: 1: 13 and a note on the session in *Chronicle WHO* 1948: 1: 146.

² *Bull. WHO* 1948: 1: 253.

insecticide, to the optimum concentration of DDT for each species, to the type of surface, etc. Experiments have also been carried out in the field, where new complications arise from the natural conditions.

In the laboratory, ingenious techniques and apparatus such as wall cages and exposure chambers—illustrated and carefully described in the article—have been perfected, to study the effect on mosquitos of the residual toxicity of DDT sprayed surfaces. The criterion used is the mortality rate of mosquitos, which is tabulated 24 or 48 hours after the experimental exposure period.

In field tests, an attempt has been made to develop methods applicable to the local conditions, i.e., to anopheline density, bionomics of the different vector species, construction materials used in buildings, climatic conditions, etc. More direct methods, such as a count of mosquitos caught inside houses, give only very approximate information, mainly because of the large number of variable factors. More reliable criteria are required, either entomological, such as the survival rate of mosquitos escaping from houses and later captured in traps, or malariological, such as the sporozoite, parasite- or spleen rates.

The author summarizes and analyses the results of residual DDT house spraying campaigns, both published and unpublished, communicated by prominent malariologists. In Italy as in Greece, DDT campaigns have effected a considerable decrease in malaria. In India, Mauritius, Panama and Puerto Rico, DDT spraying has resulted in a marked decline in the malaria infection rate. But, unfortunately, DDT is no panacea in malaria control. Certain species of mosquitos, because of their non domestic habits, are not affected by house spraying. It is therefore of vital importance before undertaking any large scale campaign to be assured of the effectiveness of DDT in relation to the bionomics of the vector species.

In an appendix, Dr. Pampana gives some indication of the cost of antimalarial campaigns with DDT, in which the insecticide has been used in solution in kerosene, in emulsion, or in suspension, the solution usually being the most expensive. The cost chiefly depends upon the price of the solvent, of the emulsifiable or wetting agent, and the cost of manpower, all of which vary according to local conditions, and to a lesser extent, upon the price of DDT. The lowest cost of any campaign so far recorded was in India—

Owing to shortage of pyrethrum and particularly of DDT, no systematic disinsectization of houses was practised, but to prevent the spread of the insect from the infested area to the uninfested area to the north, trains, automobiles, boats and aeroplanes were disinsectized.

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* All prices are post free

0.045 US dollar per person per year. In the same country it has been estimated that the cost of suppressive prophylaxis would be much higher: with atabrine, it would amount to 1.45 US dollars per person per year, with paludrine to 0.29 US dollar and with chloroquine to 1.5 US dollars.

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